

UNITED STATES DEPARTMENT OF AGRICULTURE

1917



REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE

FOR THE YEAR 1916

AND THE PROGRESS OF THE LAND OFFICE

IN THE YEAR 1916

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IN THE YEAR 1916

AND THE PROGRESS OF THE LAND OFFICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9396 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09354

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS Route 1, Box 91, Spencer Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jacob Middle Avery Last				4. DATE OF DEATH Month August Day 14 Year 1959			
5. SEX Male		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Construction			11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. 418-07-4165		17. INFORMANT Edward Tibbs Address Rt. 1, Box 91, Glen Burnie, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyperthermia DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 787.8 DUE TO (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiovascular disease							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> August 14, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-21-1959		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co., 3015 12th St., N. E.				24a. REC'D BY REGISTRAR DATE AUG 24 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hearn	

MEDICAL CERTIFICATION

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. The certificate should be executed in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. The certificate should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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3. *Implications for practice*

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U. S. GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATION

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9397

CERTIFICATE OF DEATH

Reg. Dist. No.

09356

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly		c. LENGTH OF STAY IN 1b 21 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle E Last Barrett		4. DATE OF DEATH Month Aug Day 13 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/29/1889
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) West Providence Township Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Eshelman		14. MOTHER'S MAIDEN NAME Rebecca Baird	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Hospital record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple infarctions of lung, brain, and spleen. 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Thrombophlebitis of right leg. DUE TO (c) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 Aug , 19 59 , to 13 Aug , 19 59 , that I last saw the deceased alive on 12 Aug , 19 59 , and that death occurred at 3005 A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1013 University Blvd E. Langley Park, Md DATE SIGNED AUG 17 '59			
ACTUAL SIGNATURE Francis X. Carillo, M.D.		M.D. Francis X. Carillo, M.D.	
PHYSICIAN'S NAME (Type) Francis X. Carillo, M.D.		M.D. Francis X. Carillo, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		22b. DATE THEREOF 8-13-59	
22c. NAME OF CEMETERY OR CREMATORY Everett Cemetery		22d. LOCATION (City, town, or county) (State) Bedford County, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey		24. RECEIVED BY REGISTRAR James Buchanan	
ADDRESS 1557 Weymouth Ave		DATE AUG 17 '59	
24b. REGISTRAR'S SIGNATURE Charles L. Harris			

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MEDICAL CERTIFICATION

Journal of Management Education

Environ Monit Assess (2008) 142:107–115

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09357

9398

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 20 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George County Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl		4. DATE OF DEATH Aug. 14 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 13 1959
9. AGE (In years last birthday) 20		10. IF UNDER 1 YEAR Months 20 Days 14 Min. 1959	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles G. Bell		14. MOTHER'S MAIDEN NAME Helen D. Whipple	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) +		16. SOCIAL SECURITY NO. +	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776x Prenalinity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) 776x DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 13 , 19 59 to Aug. 14 , 19 59 , that I last saw the deceased alive on Aug. 13 , 19 59 , and that death occurred at 12:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John Kehoe		M.D.	
PHYSICIAN'S NAME (Type) Dr. John Kehoe M. D.			
22a. BURIAL, CREMATION, REINTERMENT (Specify) cremation		22b. DATE THEREOF 8/25/59	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W Penn, Jr.		24a. REC'D BY REGISTRAR SEP 2 '59	
ADDRESS Administrator		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

2077204 XU2

CENTRAL OFFICE OF DEATH

5338

NAME OF DECEASED: [Illegible]

DATE OF DEATH: [Illegible]

PLACE OF DEATH: [Illegible]

TIME OF DEATH: [Illegible]

CAUSE OF DEATH: [Illegible]

MANNER OF DEATH: [Illegible]

SEX: [Illegible]

AGE: [Illegible]

HEIGHT: [Illegible]

WEIGHT: [Illegible]

HAIR: [Illegible]

EYES: [Illegible]

SKIN: [Illegible]

TEETH: [Illegible]

NOSE: [Illegible]

MOUTH: [Illegible]

THROAT: [Illegible]

STOMACH: [Illegible]

Page 4
TO HOSPITAL OR A Dying PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9399
CERTIFICATE OF DEATH

09358

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 13 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Bell		4. DATE OF DEATH Month August Day 16 Year 19 59	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 16 1959
9. AGE (In years last birthday) yrs. 13		10. IF UNDER 1 YEAR Months Days 13	
11. IF UNDER 24 HRS. Min. 13		12. CITIZEN OF WHAT COUNTRY? United States	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Charles E. Martz		14. MOTHER'S MAIDEN NAME Martha Bell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mother		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 16, 19 59 , to August 16, 19 59 , that I last saw the deceased alive on August 16, 19 59 , and that death occurred at 11:15 P , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE John Kephoe		M.D. 6300 Everdale Re., Riverdale, Md.	
PHYSICIAN'S NAME (Type) Dr. John Kephoe			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 8/25/59	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W Penn, Jr.		24a. REC'D BY REGISTRAR DATE SEP 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

2077389XV6

CERTIFICATE OF DEATH

0322

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Place of birth: _____
6. Date of death: _____
7. Time of death: _____
8. Cause of death: _____
9. Place of death: _____
10. Signature of physician: _____
11. Signature of registrar: _____
12. Date of registration: _____

13. Signature of informant: _____
14. Date of completion: _____
15. Signature of official: _____
16. Date of filing: _____
17. Signature of official: _____
18. Date of filing: _____
19. Signature of official: _____
20. Date of filing: _____
21. Signature of official: _____
22. Date of filing: _____
23. Signature of official: _____
24. Date of filing: _____
25. Signature of official: _____
26. Date of filing: _____
27. Signature of official: _____
28. Date of filing: _____
29. Signature of official: _____
30. Date of filing: _____

9478

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <u>S. Carolina Greenwood</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradbury Park</u>		c. LENGTH OF STAY IN lb <u>2 weeks</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenwood</u> 77 x 3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4731 Brookfield Dr.</u>			d. STREET ADDRESS <u>Route 2 Box 142-A.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>ELIZABETH ALBERTA BELL</u>			4. DATE OF DEATH Month <u>AUG</u> Day <u>8</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Can.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 19, 1900</u>		9. AGE (In years last birthday) <u>59</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (State or foreign country) <u>Greenwood S. Car.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Clarence P. Arnold, Brookfield, Md.</u> Address <u>4731 Brookfield</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF LIVER</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 MONTH</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>8/4</u> , 19 <u>59</u> , to <u>8/8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/8</u> , 19 <u>59</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Bruno Kolega</u> M.D.		ADDRESS (Street, city or town, state) <u>4833 S. BARNABAS Rd. WASH. 21 - D.C.</u> DATE SIGNED <u>8/8/59</u>			
PHYSICIAN'S NAME (Type) <u>BRUNO KOLEGA</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-10-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		22d. LOCATION (City, town, or county) <u>Suitland, Maryland</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers & Co. Inc.</u> ADDRESS <u>Washington, D.C.</u>			24a. REC'D BY REGISTRAR <u>AUG 12 '59</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hume</u>

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR A FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon.

9385

CERTIFICATE OF DEATH

Reg. Dist. No.

09360

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Washington, D. C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor		d. STREET ADDRESS 108 Tennessee Ave. N.W. 4922 / LaSalle Rd.	

3. NAME OF DECEASED (Type or print) AMY First L Middle BICKERTON Last		4. DATE OF DEATH Month AUG. 10, Day 1959 Year 19	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/13/1885
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR Months 7 Days 10 Hours 10 Min.	IF UNDER 24 HRS. Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXAMINER,		10b. KIND OF BUSINESS OR INDUSTRY U. S. GOV'T.	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN A. BICKERTON		14. MOTHER'S MAIDEN NAME MARY E. LONGION	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. ----	17. INFORMANT Wm. J. Brown, 7221 Barnett Rd., Bethesda, Md.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Vascular 422.1 DUE TO dissect Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) dissect DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 years
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture right hip 1951, Fracture left hip 1957		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month 19 Day 19 Year 1959 Hour a. 11 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 1955 to Aug 10, 1959 , that I last saw the deceased alive on Aug 9, 1959 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE J. Chester Brady	DATE SIGNED 8/10/59
PHYSICIAN'S NAME (Type) J. CHESTER BRADY	ADDRESS (Street, city or town, state) 35 N. Y. AVE., N.W., WASH. D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8/13/59	22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM.	22d. LOCATION (City, town, or county) (State) SILVER SPRING, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Paulino Inc		ADDRESS 1756 Pa. Ave., N.W. DC	24a. REC'D BY REGISTRAR AUG 14 59
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

VS A15 (4)
ISM 9/55

CERTIFICATE OF DEATH

0382

Page Two of

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE 12-5-29		6. BIRTH PLACE MOBILE, ALA.	
7. MARRIAGE Married		8. DEATH DATE 4-4-68		9. DEATH PLACE MEMPHIS, TENN.	
10. DEATH TIME 10:00 PM		11. DEATH CAUSE MURDER		12. DEATH MANNER Homicide	
13. DEATH LOCATION Room 906, Lorraine Motel		14. DEATH CITY Memphis		15. DEATH COUNTY Shelby	
16. DEATH STATE Tennessee		17. DEATH ZIP 38103		18. DEATH DISTRICT North	
19. DEATH WARD North		20. DEATH BLOCK 1000		21. DEATH LOT 1000	
22. DEATH TRACT North		23. DEATH SECTION 1000		24. DEATH SUBSECTION 1000	
25. DEATH LOT 1000		26. DEATH SECTION 1000		27. DEATH SUBSECTION 1000	
28. DEATH LOT 1000		29. DEATH SECTION 1000		30. DEATH SUBSECTION 1000	
31. DEATH LOT 1000		32. DEATH SECTION 1000		33. DEATH SUBSECTION 1000	
34. DEATH LOT 1000		35. DEATH SECTION 1000		36. DEATH SUBSECTION 1000	
37. DEATH LOT 1000		38. DEATH SECTION 1000		39. DEATH SUBSECTION 1000	
40. DEATH LOT 1000		41. DEATH SECTION 1000		42. DEATH SUBSECTION 1000	
43. DEATH LOT 1000		44. DEATH SECTION 1000		45. DEATH SUBSECTION 1000	
46. DEATH LOT 1000		47. DEATH SECTION 1000		48. DEATH SUBSECTION 1000	
49. DEATH LOT 1000		50. DEATH SECTION 1000		51. DEATH SUBSECTION 1000	
52. DEATH LOT 1000		53. DEATH SECTION 1000		54. DEATH SUBSECTION 1000	
55. DEATH LOT 1000		56. DEATH SECTION 1000		57. DEATH SUBSECTION 1000	
58. DEATH LOT 1000		59. DEATH SECTION 1000		60. DEATH SUBSECTION 1000	
61. DEATH LOT 1000		62. DEATH SECTION 1000		63. DEATH SUBSECTION 1000	
64. DEATH LOT 1000		65. DEATH SECTION 1000		66. DEATH SUBSECTION 1000	
67. DEATH LOT 1000		68. DEATH SECTION 1000		69. DEATH SUBSECTION 1000	
70. DEATH LOT 1000		71. DEATH SECTION 1000		72. DEATH SUBSECTION 1000	
73. DEATH LOT 1000		74. DEATH SECTION 1000		75. DEATH SUBSECTION 1000	
76. DEATH LOT 1000		77. DEATH SECTION 1000		78. DEATH SUBSECTION 1000	
79. DEATH LOT 1000		80. DEATH SECTION 1000		81. DEATH SUBSECTION 1000	
82. DEATH LOT 1000		83. DEATH SECTION 1000		84. DEATH SUBSECTION 1000	
85. DEATH LOT 1000		86. DEATH SECTION 1000		87. DEATH SUBSECTION 1000	
88. DEATH LOT 1000		89. DEATH SECTION 1000		90. DEATH SUBSECTION 1000	
91. DEATH LOT 1000		92. DEATH SECTION 1000		93. DEATH SUBSECTION 1000	
94. DEATH LOT 1000		95. DEATH SECTION 1000		96. DEATH SUBSECTION 1000	
97. DEATH LOT 1000		98. DEATH SECTION 1000		99. DEATH SUBSECTION 1000	
100. DEATH LOT 1000		101. DEATH SECTION 1000		102. DEATH SUBSECTION 1000	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9400 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09362

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Utah b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brigham City 81X-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ieland Memorial H spital				d. STREET ADDRESS 343 North 2nd West		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Grant Middle Alonzo Last Black				4. DATE OF DEATH Month August Day 13 Year 19 59			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-2-86		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 72 Days 72	IF UNDER 24 HRS. Hours 72 Min. 72
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Heating engineer		11. BIRTHPLACE (State or foreign country) Arizona		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Grant Black				14. MOTHER'S MAIDEN NAME Lucrecia Maxwell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 528-05-4007		17. INFORMANT Ruth R. Black; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO 442X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		August 13, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF 8/13/59		22c. NAME OF CEMETERY OR CREMATORY Brigham City		22d. LOCATION (City, town, or county) (State) Utah	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE AUG 17 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 10 MAY 1900 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of deceased		Sex		Age		Date of birth		Place of birth		Usual residence		Cause of death		Manner of death	
John F. Murphy		Male		35		May 1, 1865		Boston, Mass.		Boston, Mass.		Died of heart failure		Natural	
Occupation		Trade		Education		Religion		Marital status		Previous illness		Time of death		Place of death	
Clerk		Clerk		High School		Roman Catholic		Married		None		May 10, 1900		Boston, Mass.	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Minister		Signature of Justice		Signature of Notary		Signature of Physician		Signature of Nurse	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

100-1000

9401

CERTIFICATE OF DEATH

09364

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital				e. STREET ADDRESS 6400 Telegraph Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Hattie Middle Irene Last Boteler				4. DATE OF DEATH Month August Day 10 Year 1959			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-9-80	9. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Walker, George Noble				14. MOTHER'S MAIDEN NAME Laneheart, Genevia			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Robert Boteler		Address Washington D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Acute Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerotic Heart DUE TO (c) 5 yrs				INTERVAL BETWEEN ONSET AND DEATH 3 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1940 , to Aug 10, 1959 , that I last saw the deceased alive on Aug 10, 1959 , and that death occurred at 9 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4404 Queensbury Rd., Riverdale, Md. DATE SIGNED August 10, 1959							
ACTUAL SIGNATURE L. W. Malin M.D.							
PHYSICIAN'S NAME (Type) L. W. Malin, M.D.							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/13/59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE AUG 12 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9478 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09365

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rogers Heights		c. LENGTH OF STAY IN lb 21 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rogers Heights			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4906 Donovan Place				d. STREET ADDRESS 4906 Donovan Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carl Middle Huntington Last Broedel				4. DATE OF DEATH Month August Day 13 Year 19 59			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-7-08	9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Geologist		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Max Broedel				14. MOTHER'S MAIDEN NAME Ruth Huntington			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Amelia Broedel; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 976x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gunshot wound of head DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted gun shot wound					
20c. TIME OF INJURY Month, Day, Year 6.10 a. m. 8-13- 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Rogers Heights Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney EXAMINER'S NAME (Type) John T. Maloney, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED August 13, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/15/59		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. BURIAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.				24a. REC'D BY REGISTRAR DATE AUG 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be written in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific information required.

Abstract

Send no money today

Author's address: Department of Mathematics, University of Illinois at Chicago, Chicago, IL 60607, USA.

G.M., volume 8, p. 107

2011.11.21

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmount Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		c. LENGTH OF STAY IN 1b 2 days		d. STREET ADDRESS 1002 60th Ave.	
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Brooks		4. DATE OF DEATH Month Aug Day 6 Year 1959		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Aug 4, 1959		9. AGE (In years last birthday) 12		10. IF UNDER 1 YEAR Months 12 Days 11 Hours 35	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME William J. Brooks		14. MOTHER'S MAIDEN NAME Thelma Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Mother,		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity (Birth wt 1 lb) 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Choke DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) College Park, Md.		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 3:45 A. M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 6905 Baltimore Ave., College Park, Md.		DATE SIGNED	
ACTUAL SIGNATURE Thomas A. Christensen		M.D.			
PHYSICIAN'S NAME (Type) Dr. Thomas A Christensen					
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 8/25/59		22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.	
22d. LOCATION (City, town, or county) Cheverly, Md.		22e. (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Harry W Penn Jr		ADDRESS Administrator		24a. REC'D BY REGISTRAR DATE SEP 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Jones					

VS A15 (4)
15M 9/58

STATEMENT OF EXPORTS

1913

Country of Origin

Country of Destination

Quantity

Value

Remarks

1000-0000

1000-0000

1000-0000

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9480 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09367

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glass Manor			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Oxon Hill, Maryland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 101- Audrey Lane S.E.				d. STREET ADDRESS 6050- Bock Road S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM First B. Middle BROWN Last SR.				4. DATE OF DEATH Month August Day 1st. Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15- 1892		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Bur. of Engraving		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas H. Brown				14. MOTHER'S MAIDEN NAME Margaret Barry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs Margaret V. Brown Same as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardio Vascular Renal Disease (c) Cardio Vascular Renal Disease DUE TO (c) Cardio Vascular Renal Disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES I. BOYD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF August 4-59		22c. NAME OF CEMETERY OR CREMATORY St. Ignatius Cemetery		22d. LOCATION (City, town, or county) (State) Oxon Hill, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 1661- Good Hope Road S.E. Washington, DC				24a. REC'D BY REGISTRAR DATE AUG 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

9481

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09368

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clarence Middle - Last Burnett		4. DATE OF DEATH Month 8 Day 30 Year 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/11/55
9. AGE (In years last birthday) 3 yrs.		10. IF UNDER 1 YEAR Months - Days - Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Burnett		14. MOTHER'S MAIDEN NAME Hester ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mr. & Mrs. James Burnett		Address 1715 H. St., NE., Apt 3, Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculous meningitis 010 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 months		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/28 , 19 59 , to 8/30 , 19 59 , that I last saw the deceased alive on 8/30 , 19 59 , and that death occurred at 6:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Glenn Dale Hospital DATE SIGNED 8/30/59 ACTUAL SIGNATURE Moe Weiss M.D. Glenn Dale, Md. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 12		22b. DATE THEREOF 8-31-59	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Bassett		24a. REC'D BY REGISTRAR 17227	
24b. REGISTRAR'S SIGNATURE SEP 3 '59		24c. DATE SEP 3 '59	

CERTIFICATE OF DEATH

9481

Washington

2 days

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John John (John)

John John (John)

John John (John)

John John (John)

John John (John)

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John John (John)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9403

CERTIFICATE OF DEATH

09369

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN 1b 15X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital, Laurel, Md.		d. STREET ADDRESS Fairland-Colesville Rd., Rte 2, Box 149A	
3. NAME OF DECEASED (Type or print) SOPHIE First BURTON Middle August Last 17 19 59		4. DATE OF DEATH August 17 19 59	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1917
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wojciech Rutkowski		14. MOTHER'S MAIDEN NAME Mary Markowska	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Edward A. Burton, husband, same as patient		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) miliary tuberculosis 019.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 11, 1959 , to August 17, 1959 , that I last saw the deceased alive on August 17, 1959 , and that death occurred at 9:35 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Richard Compton M.D.		ADDRESS (Street, city or town, state) 612 Main Street, Laurel, Md. DATE SIGNED 17 August 1959	
PHYSICIAN'S NAME (Type) J. Richard Compton, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Aug 20, 1959	Union Cemetery	Burtonsville Md
23. FUNERAL DIRECTOR'S SIGNATURE De Witt Davidson, Laurel Md		24. REC'D BY REGISTRAR DATE AUG 24 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Colleen S. King	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, stating the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										09370
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.					
b. CITY OR TOWN Edmonston			c. LENGTH OF STAY IN 1b transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmonston					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) B & O Railroad tracks					d. STREET ADDRESS 5300 46th Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Jacob Last Butler					4. DATE OF DEATH Month August Day 14 Year 19 59					
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-19-25		9. AGE (In years last birthday) 33 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver			10b. KIND OF BUSINESS OR INDUSTRY Lumber		11. BIRTHPLACE (State or foreign country) Washington, D.C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John XXXX Jacob Butler Sr.					14. MOTHER'S MAIDEN NAME Lillian Mitchell					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-20-2431		17. INFORMANT Frances Butler			Address Same as # 2 (Wife)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 802x DUE TO Conditions, if any, which gave rise to immediate cause (b) Decapitation (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Run over by a B & O Railroad train							
20c. TIME OF INJURY Month, Day, Year Hour 11 Min. 20 p. m. 8-13 19 59			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) R.R. Tracks		20f. (City or town) (County) (State) Edmonston Pr. Geo. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE John T. Maloney EXAMINER'S NAME (Type) John T. Maloney, M.D.					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED August 14, 1959
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug-18-1959		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			22d. LOCATION (City, town, or county) (State) Washington, D. C.			
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. 3015 12th St., N. E.					24a. REC'D BY REGISTRAR DATE AUG 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased John J. [illegible]		Date of Death August 14, 1922	
Place of Death [illegible]		Age 33	
Sex Male		Race White	
Cause of Death [illegible]		Manner of Death Natural	
Signature of Medical Examiner [illegible]			
Date of Examination August 14, 1922			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09371

9404

Reg. Dist. No.

FOR STATE HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 7805 Alpine Street Apt.# 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LAWRENCE VINCENT BYRNES				4. DATE OF DEATH Month August Day 23rd , Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1887		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Union Representative			10b. KIND OF BUSINESS OR INDUSTRY Brotherhood of RR Engineers		11. BIRTHPLACE (State or foreign country) Boundbrook, N.J.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Lawrence B. Byrnes				14. MOTHER'S MAIDEN NAME Bridgette Murray			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 719-18-7942		17. INFORMANT Address Josephine T. Byrnes, 7805 Alpine St. Dist. Hgts. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-vascular renal disease DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 		(County) (State) 	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined monner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 8/24/59		22c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery County, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				24a. REC'D BY REGISTRAR DATE AUG 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the cause thereof should be stated in the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 3 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9405 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09372

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY in 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emma Hall Calver		4. DATE OF DEATH Aug. 22, 1959	
5. SEX Female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-21-1901
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Hall		14. MOTHER'S MAIDEN NAME Katherine Garner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 579-38-6404	
17. INFORMANT Elizabeth Walls; same address as # 2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage and shock 981X DUE TO (b) Shot gun wound of chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by another person with shot gun.	
20c. TIME OF INJURY Month, Day, Year 12.30 p.m. 8-22-1959		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) House		20f. (City or town) Bowie (County) Prince Georges (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED August 22, 1959	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) 8-25-1959		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Bowie		22d. LOCATION (City, town, or county) Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Frazier's Funeral Home		ADDRESS 389 R.D. Ave N.W.	
24a. REC'D BY REGISTRAR DATE AUG 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

Figure 1

12. *Journal of the American Medical Association*, 273, 1995, 1000-1001.

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1. *Journal of the American Medical Association*, 1997; 278: 1039-1044.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

9387

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09373

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>3815-49th St.</u> b. COUNTY <u>HHH</u> St. <u>N.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE MD</u>		c. LENGTH OF STAY IN 1b <u>Wash. D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HYATTSVILLE CONVALESCENT REST HOME</u>		d. STREET ADDRESS <u>3815-49th St.</u> Street <u>47x3</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>CANNING</u> Last <u>CANNING</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/14/1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>West Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>George A. Thorne</u>		14. MOTHER'S MAIDEN NAME <u>-- Ramsey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>440-01-2331</u>	
17. INFORMANT <u>MRS. MAIZE WHITMER</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1954</u> to <u>Aug. 27, 1959</u> , that I last saw the deceased alive on <u>Aug. 27, 1959</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harold F. McCann</u> M.D.		ADDRESS (Street, city or town, state) <u>3355-16th N.W.</u>	
DATE SIGNED <u>Aug 31 '59</u>		DATE SIGNED <u>Aug 31 '59</u>	
PHYSICIAN'S NAME (Type) <u>HAROLD F. MCCANN</u>		<u>WASH 10, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		22b. DATE THEREOF <u>8/29/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Old Cathedral Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Oklahoma City, Okla.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. N. Harris Co.</u>		ADDRESS <u>2901-14th St. N.W.</u>	
DATE <u>AUG 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

CERTIFICATE OF DEATH

9387

1. NAME OF DECEASED WILLIAM J. BROWN		2. SEX Male	
3. AGE 45		4. DATE OF BIRTH 1900	
5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION Carpenter	
7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1925	
9. NAME OF SPOUSE JANE BROWN		10. PLACE OF MARRIAGE BALTIMORE, MARYLAND	
11. CAUSE OF DEATH Heart Disease		12. PLACE OF DEATH Home	
13. DATE OF DEATH 1945		14. TIME OF DEATH 10:00 AM	
15. SIGNATURE OF PHYSICIAN J. M. Smith		16. SIGNATURE OF REGISTRAR J. M. Smith	
17. SIGNATURE OF WITNESSES J. M. Smith, J. M. Smith		18. SIGNATURE OF DECEASED J. M. Smith	
19. SIGNATURE OF FUNERAL HOME J. M. Smith		20. SIGNATURE OF BURIAL PLACE J. M. Smith	
21. SIGNATURE OF CEMETERY J. M. Smith		22. SIGNATURE OF INTERMENT J. M. Smith	
23. SIGNATURE OF BURIAL PLACE J. M. Smith		24. SIGNATURE OF INTERMENT J. M. Smith	
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100

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. MARITAL STATUS
8. DATE OF MARRIAGE
9. NAME OF SPOUSE
10. PLACE OF MARRIAGE
11. CAUSE OF DEATH
12. PLACE OF DEATH
13. DATE OF DEATH
14. TIME OF DEATH
15. SIGNATURE OF PHYSICIAN
16. SIGNATURE OF REGISTRAR
17. SIGNATURE OF WITNESSES
18. SIGNATURE OF DECEASED
19. SIGNATURE OF FUNERAL HOME
20. SIGNATURE OF BURIAL PLACE
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9483

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09374

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradbury Park</u>		c. LENGTH OF STAY IN 1b <u>6 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradbury Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2015 Gaylord Drive</u>				d. STREET ADDRESS <u>2015 Gaylord Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Patrick</u> Middle <u>Michael</u> Last <u>Carpenter</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 21, 1905</u>		9. AGE (In years last birthday) <u>54</u> yrs.	10. UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operating Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. - 6</u>	
13. FATHER'S NAME <u>Michael Carpenter</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Tena A Carpenter, same as dec'd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442x acute congestive heart failure</u> DUE TO (b) <u>Caschioriuscular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-27-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Southland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u>				24a. REC'D BY REGISTRAR <u>1661- Good Hope Rd SE Wash DC</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur & Thana</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - CALIFORNIA MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0255

0255

SEE INSTRUCTIONS

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. COLOR</p>		<p>9. RELIGION</p>		<p>10. EDUCATION</p>		<p>11. SOCIAL CLASS</p>		<p>12. PLACE OF DEATH</p>	
<p>13. CAUSE OF DEATH</p>		<p>14. MANNER OF DEATH</p>		<p>15. TIME OF DEATH</p>		<p>16. PLACE OF DEATH</p>		<p>17. SIGNATURE OF EXAMINER</p>		<p>18. SIGNATURE OF WITNESS</p>	
<p>19. SIGNATURE OF DECEASED</p>		<p>20. SIGNATURE OF NEXT OF KIN</p>		<p>21. SIGNATURE OF SURGEON</p>		<p>22. SIGNATURE OF JUDGE</p>		<p>23. SIGNATURE OF CLERK</p>		<p>24. SIGNATURE OF OTHER</p>	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, CALIFORNIA, AND A COPY IS TO BE FURNISHED TO THE LOCAL HEALTH OFFICIALS.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Item 2 Film 255 4-1-60 ams									
9406									
CERTIFICATE OF DEATH									
Reg. Dist. No. 09375									
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges A.A.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, RFD #1			02x.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital					d. STREET ADDRESS Bacontown			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Boy " B " Last Carter					4. DATE OF DEATH Month Aug Day 16 Year 19 59				
5. SEX Male		6. COLOR OR RACE Black		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11 Aug 1959		9. AGE (In years last birthday) yrs. 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lester Warren Carter					14. MOTHER'S MAIDEN NAME Delores Cytha Day				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Mother			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Cerebral (c) DUE TO								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 11 Aug, 19 59 to 16 Aug, 19 59 that I last saw the deceased alive on 16 Aug, 19 59, and that death occurred at 4:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 8/17/59									
ACTUAL SIGNATURE Thomas A. Christensen M.D.									
PHYSICIAN'S NAME (Type) Dr. Thomas Christensen, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation			22b. DATE THEREOF 8/25/59		22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.			22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W Penn Jr Administrator.			24a. REC'D BY REGISTRAR DATE SEP 2 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Evans				

2277224XVI

CERTIFICATE OF DEATH

3408

DECEASED

DATE

TIME

PLACE

CAUSE

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9407
CERTIFICATE OF DEATH

05376

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lanham</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>41 Lanham</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>916 Montgomery St</i>		d. STREET ADDRESS <i>916 Montgomery St</i>	
3. NAME OF DECEASED (Type or print) <i>Harry Martin Leach</i>		4. DATE OF DEATH <i>August 15 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 30 1884</i>
9. AGE (In years last birthday) <i>74</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tram operator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Tram yard</i>	
11. BIRTHPLACE (State or foreign country) <i>Charlottesville, Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Emmanuel Martin Leach</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Elizabeth Borg</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mrs Harry M. Leach</i>		Address <i>Lanham Md 916 Montgomery St</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Leukemia Myocarditis</i> <i>422.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <i>18 mo.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 1</i> , 1959, to <i>Aug 15</i> , 1959, that I last saw the deceased alive on <i>Aug 15</i> , 1959, and that death occurred at <i>11:25 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert S. McGeney</i> M.D.		ADDRESS (Street, city or town, state) <i>402 MAIN ST. LAUREL, MD.</i> DATE SIGNED _____	
PHYSICIAN'S NAME (Type) _____		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 22b. DATE THEREOF <i>Aug 18, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Trinity Hill Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Laurel Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>De Witt Connelley</i> ADDRESS <i>Laurel Md</i>		24a. REC'D BY REGISTRAR DATE <i>AUG 19 59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Rouse</i>			

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
9484											
CERTIFICATE OF DEATH											
Reg. Dist. No. 09377											
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs			c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Camp Springs						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews					d. STREET ADDRESS USAF Hospital Andrews			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALESHIA Middle CHAMBERS Last (WILLIAMS)					4. DATE OF DEATH Month August Day 10 Year 1959						
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8 August 1959		9. AGE (In years last birthday) yrs. 0 Months 3 Days 3 Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Peter Chambers					14. MOTHER'S MAIDEN NAME Marian A. Torain (Williams)						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. No		INFORMANT Address Marian A. Torain Williams (Mother)						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 Respiratory failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c) _____									INTERVAL BETWEEN ONSET AND DEATH 48 hours		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 8 August , 19 59 , to 10 August , 19 59 , that I last saw the deceased alive on 10 August , 19 59 , and that death occurred at 5:55 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED											
ACTUAL SIGNATURE Richard I. Breuer			M.D. USAF Hospital Andrews								
PHYSICIAN'S NAME (Type) RICHARD I. BREUER, Captain USAF MC Andrews Air Force Base, Wash 25, D. C.											
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			22b. DATE THEREOF AUG 13, 1959		22c. NAME OF CEMETERY OR CREMATORY WOODLAWN			22d. LOCATION (City, town, or county) (State) 4611 BENNING Rd. S.E. D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE B.F. TAYLOR					ADDRESS B.F. Taylor 1702 12TH ST. N.W.			24a. REC'D BY REGISTRAR DATE AUG 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

2050 314XV0

1992-1993

1992, 1993, 1994

MEDICAL CERTIFICATION

VS A15 (4)
ISM 10/57

CERTIFICATE OF DEATH

3498

DEPARTMENT OF HEALTH
BALTIMORE, MARYLAND
OFFICE OF THE REGISTRAR
1000 PENNSYLVANIA AVENUE
WASHINGTON, D. C.

NAME OF DECEASED _____	
SEX _____	
AGE _____	
DATE OF BIRTH _____	
PLACE OF BIRTH _____	
OCCUPATION _____	
CAUSE OF DEATH _____	
PLACE OF DEATH _____	
TIME OF DEATH _____	
SIGNATURE OF REGISTRAR _____	
DATE _____	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9409
CERTIFICATE OF DEATH

09379

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley	c. LENGTH OF STAY IN 1b 21 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Upper Marlboro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS Route 2, Box 201	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Netto Middle Last Colbert		4. DATE OF DEATH Month Aug. Day 6 Year 1959	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Lohis Cosey	
14. MOTHER'S MAIDEN NAME Elizabeth Stewart		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. _____		INFORMANT Address Annie West 213 Warren Street, N.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO Atherosclerotic Heart Disease (c) Atherosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 2 hrs 3 wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 15 , 19 59 , to Aug. 6 , 19 59 , that I last saw the deceased alive on 6 Aug , 19 59 , and that death occurred at 8:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas J. Maloney M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 4814 - 71st Ave. N.E. 6 Aug 59 Lankford Hills Md.	
PHYSICIAN'S NAME (Type) Dr. Thomas Maloney			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 8/10/59	22c. NAME OF CEMETERY OR CREMATORY Woodlawn	22d. LOCATION (City, town, or county) (State) D.C.
23. FUNERAL DIRECTOR'S SIGNATURE John T. Stewart		24a. REC'D BY REGISTRAR 30-H-N-# DATE AUG 12 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

2408

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		35		Jan 1, 1900		New York, N.Y.	
Usual Residence		Occupation		Cause of Death		Manner of Death		Place of Death	
123 Main St, Los Angeles, Cal.		Teacher		Heart Disease		Natural		Home	
Date of Death		Time of Death		Physician		Hospital		Burial Place	
Jan 15, 1935		10:30 AM		Dr. J. Smith		St. Mary's		Cemetery	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Death Certifier	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9485 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09380

Reg. Dist. No.

1. PLACE OF DEATH Prince Georges a. COUNTY Maryland MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Florida b. COUNTY --	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carrolton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Petersburg 48X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6009 Westbrook Drive		d. STREET ADDRESS 4305 78th Lane, North	
3. NAME OF DECEASED (Type or print) First Middle Last Grace Darling Comingore		4. DATE OF DEATH Month Day Year August 23, 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18, 1897
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New York City		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. McIntyre		14. MOTHER'S MAIDEN NAME Mollie B. Stoller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 578-40-9989	
17. INFORMANT Edward Comingore - Same #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic Cardiovascular Disease DUE TO (c) 3 yrs INTERVAL BETWEEN ONSET AND DEATH 1 minute		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 24, 1959 , to August 23, 1959 , that I last saw the deceased alive on Aug 18, 1959 , and that death occurred at 3 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE William D. Rosson MD		ADDRESS (Street, city or town, state) 5304 Annapolis Road DATE SIGNED 8/23/59	
PHYSICIAN'S NAME (Type) William D. Rosson		Bladensburg, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/27/1959	22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St., N.W.		24a. REC'D BY REGISTRAR DATE AUG 25 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. RACE White		5. DATE OF BIRTH 1890		6. PLACE OF BIRTH Maryland	
7. DATE OF DEATH 1950		8. TIME OF DEATH 10:00 AM		9. PLACE OF DEATH Home		10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. SIGNATURE OF PHYSICIAN J. H. Harris	
13. SIGNATURE OF REGISTRAR J. H. Harris		14. SIGNATURE OF WITNESSES J. H. Harris		15. SIGNATURE OF DECEASED J. H. Harris		16. SIGNATURE OF NEXT OF KIN J. H. Harris		17. SIGNATURE OF CLERK J. H. Harris		18. SIGNATURE OF JUDGE J. H. Harris	

1

9410

CERTIFICATE OF DEATH

Reg. Dist. No.

09381

1. PLACE OF DEATH COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 31 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clarence Middle M Last Condrey Sr		4. DATE OF DEATH Month Aug Day 7 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 8- 1895
9. AGE (In years lost birthday) yrs. 63 63		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mattress maker		10b. KIND OF BUSINESS OR INDUSTRY J. W. Hall & Son CHESTERFIELD Co. VA.	
11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ENNETT A. CONDREY		14. MOTHER'S MAIDEN NAME LIZZIE J. BARWEGGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 1		16. SOCIAL SECURITY NO. 579-01-0839	
17. INFORMANT Lilly Condrey, Wife, 3708 35th St. Md.		Address Mt Rainier Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of liver probably metastatic 156.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Primary source unknown DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 6 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Manth. Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7-6 , 19 59 , to 8-7 , 19 59 , that I last saw the deceased alive on 8-6 , 19 59 , and that death occurred at 4:10A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Waldo B. Moyers M.D.		ADDRESS (Street, city or town, state) 3503 Perry St. 8-7-59	
PHYSICIAN'S NAME (Type) Dr. W. B. Moyers		Mt. Rainier Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/10/59	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home, Inc.		24a. REC'D BY REGISTRAR DATE AUG 12 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Frank

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1910

Married

51 days

5735 5084 5084

Prison and Mental Hospital

County of

State of

1902-1903

Wife

1910

1910-1911 Early Census, 1910, 1911, 1912

1910

W. W. R. R. R.

Reg. Dist. No.

22a. BURIAL, CREMATION, REMAINS (Specify) cremation	22b. DATE THEREOF 8/28/59	22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harry W Penn Jr</i>		ADDRESS Harry W Penn Jr Administrator.	24a. REC'D BY REGISTRAR DATE SEP 2 '59
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>

VS A15 (4)
15M 9/58

2077289xv2

CERTIFICATE OF DEATH

1933

John Doe, Jr.

John Doe, Jr.

in his

proper person

John Doe, Jr. born 1900

John Doe, Jr. born 1900

John Doe, Jr.

John Doe, Jr.

John Doe, Jr.

John Doe, Jr.

John Doe, Jr.

John Doe, Jr.

John Doe, Jr.

John Doe, Jr.

John Doe, Jr. born 1900

John Doe, Jr. born 1900

John Doe, Jr. born 1900

John Doe, Jr. born 1900

John Doe, Jr. born 1900

John Doe, Jr. born 1900

John Doe, Jr. born 1900

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate filing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

1X
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9486 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09383

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg		c. LENGTH OF STAY IN 1b 14 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5414 Tilden Road				d. STREET ADDRESS 5414 Tilden Road			
3. NAME OF DECEASED (Type or print) First Middle Last Philip Sam Danna				4. DATE OF DEATH Month Day Year August 29 19 59			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-3-08	
9. AGE (In years last birthday) 51 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		11. BIRTHPLACE (State or foreign country) Delaware La.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Danna				14. MOTHER'S MAIDEN NAME Nancy De Angelo			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1941 579-03-0249		17. INFORMANT Address Anna W. Danna; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exhaustion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the lateral wall of the pharynx. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Sept 1, 1959		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) Arlington Va.				22e. REC'D BY REGISTRAR DATE SEP 4 '59		22f. REGISTRAR'S SIGNATURE <i>Arthur L. Kane</i>	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.							

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

John T. Maloney, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

August 30, 1959

5. *Conclusions*

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00406-20-0113

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10-10-95

...and it is the first time that the ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

9382

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09384

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4707 Branchville Road		d. STREET ADDRESS 4707 Branchville Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Issac Middle Franklin Last Davis		4. DATE OF DEATH Month Aug Day 28 Year 1959- 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 7
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 52 Days 52 Hours 52 Min. 52	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent C. & P Telephone Co		10b. KIND OF BUSINESS OR INDUSTRY Tennessee	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Franklin E. Davis		14. MOTHER'S MAIDEN NAME Hattie K Karns	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no	
17. INFORMANT Alleda V Davis		Address College Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 157X IMMEDIATE CAUSE (a) Carcinoma Pancreas DUE TO (b) 7 mos Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/24 , 19 59 , to 8/28 , 19 59 , that I lost saw the deceased alive on 8/26 , 19 59 , and that death occurred at 10:35 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. C. Kirchner		ADDRESS (Street, city or town, state) 6480-N.H. Ave	
PHYSICIAN'S NAME (Type) R. C. KIRCHNER		DATE SIGNED 8-28-59	
22a. BURIAL, CREMATION, etc. Burial, 18 Aug 31, 1959		22b. NAME OF CEMETERY OR INTERMENT PLACE Fort Lincoln	
22c. LOCATION (City, town, or county) (State) Colmar Manor, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR SEP 1 1959		24b. REGISTRAR'S SIGNATURE Charles E. Howard	

1931

9382

TESTIMONY OF DEATH

Princess Louise's

College Park, Md.

4200 Pennsylvania Road

1931

1931

1931

1931

1931

1931

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1931

1931

1931

1931

1931

1931

1931

1931

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9412 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09385

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 9th Street West		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ellis Middle Cross Last Day				4. DATE OF DEATH Month August Day 12, Year 19 59			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-10-85		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Magistrate		10b. KIND OF BUSINESS OR INDUSTRY Pr. Geo. County		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Day				14. MOTHER'S MAIDEN NAME Florence Cross			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. 718-14-9806		17. INFORMANT Address Ellis C. Day; 1006 Maple Avenue, Bowie, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO -- Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c), stating the underlying cause lost. DUE TO -- (c)</p> </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> August 13, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/15/59		22c. NAME OF CEMETERY OR CREMATORY Holy Trinity Cemetery		22d. LOCATION (City, town, or county) (State) Collington Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. Gasch's Sons Hyattsville Md.				24a. REC'D BY REGISTRAR AUG 17 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09386

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville Md.				c. LENGTH OF STAY IN 1b 4 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3410 Fairland Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William Blaine Dayman				4. DATE OF DEATH Month Day Year Aug 25, 19 59			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 11, 1885	
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Railroad Engineer				10b. KIND OF BUSINESS OR INDUSTRY Pa			
11. BIRTHPLACE (State or foreign country) U S A				12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME John Dayman				14. MOTHER'S MAIDEN NAME Mary ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 716 01 1659			
17. INFORMANT Samuel H Dayman				Address Beltsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) extensive atherosclerotic Heart Disease DUE TO (c) Emphysema severe, ch. bronchiectasis							INTERVAL BETWEEN ONSET AND DEATH 1 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Pa				(County) (State)			
21. I certify that I attended the deceased from 8-8 , 19 59 , to 8-25 , 19 59 , that I last saw the deceased alive on 8-25 , 19 59 , and that death occurred on 8-25 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE George Hageage				ADDRESS (Street, city or town, state) 3717-38 1/2 Ave Orange City, Pa			
DATE SIGNED 8-26-59							
PHYSICIAN'S NAME (Type) Transportation 8/26/59				22b. DATE THEREOF 8/26/59			
22c. NAME OF CEMETERY OR CREMATORY Philadelphia				22d. LOCATION (City, town, or county) (State) Pa			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE AUG 28 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9413 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09387

Item 6 Film 247 8-31-59 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>THOMAS</u> First <u>NATHANIEL</u> Middle <u>DENT</u> Last		4. DATE OF DEATH August 24th, 1959 Month Day Year	
5. SEX <u>Male</u>	6. COLOR OF RACE <u>White</u> <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 17th, 1959</u>
9. AGE (In years last birthday) yrs. <u>3</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None--Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Cheverly, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13. FATHER'S NAME <u>John Wesley Sellman</u>		14. MOTHER'S MAIDEN NAME <u>Alice Lucille Dent</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Alice L. Dent, Box #159 Route #1 Upper Marlboro Md.</u> Address			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronche-pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Md.</u>	
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE <u>James I. Boyd</u>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
EXAMINER'S NAME (Type) <u>James I. Boyd</u>	DATE SIGNED <u>8/24/1959</u>

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-26-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forrestville</u>	22d. LOCATION (City, town, or county) (State) <u>Forestville, Md.</u>
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23. FUNERAL DIRECTOR'S SIGNATURE <u>Myrtle K. Rollins</u>	ADDRESS <u>4339 Hunt Pl., N.E.</u>	24a. REC'D BY REGISTRAR <u>DATE AUG 27 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>
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2077161XV4

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

1

MISSISSIPPI MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BIRMINGHAM 18

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. Includes checkboxes for various conditions and a section for the medical examiner's signature and seal.

NAME: _____

AGE: _____

SEX: _____

RACE: _____

DATE OF DEATH: _____

PLACE OF DEATH: _____

Cause of Death: _____

Medical Examiner's Signature: _____

Seal: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9488

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09388

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi		c. LENGTH OF STAY IN 1b 3 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) 2525 Buck Lodge Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANTOINETTA BARRA Di Trapani		4. DATE OF DEATH Month 8 Day 25 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27th, 1888
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Barra		14. MOTHER'S MAIDEN NAME Concettina DiBlasa	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Dorothea DiTrapani, 2525 Buck Lodge Rd. Adelphi, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis - Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-27 , 19 57 , to 8-25 , 19 59 , that I last saw the deceased alive on 8-25 , 19 59 , and that death occurred at 3 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R.D. Baker M.D.		DATE SIGNED 8-25-59	
PHYSICIAN'S NAME (Type) R.D. BAKER, M.D.		ADDRESS (Street, city or town, state) 2513 Buck Lodge Rd. ADELPHI, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/28/1959	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE AUG 28 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Howard			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

8414

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09389

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly		c. LENGTH OF STAY IN 1b 1hr. 15 min	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle M. (Apllessis) Duplessis		4. DATE OF DEATH Month August Day 12 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/4/87
9. AGE (In years last birthday) 72 yrs.		10. UNDER 1 YEAR Months 72 Days 12 Hours 15 Min.	11. UNDER 24 HRS. Months 72 Days 12 Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) United States		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Unknown		14. MOTHER'S M maiden NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT John Soper		Address Son 112 Soper La Seat Pleasant	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration + Cachexia 788.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 19 , 19 59 , to Aug. 12 , 19 59 , that I last saw the deceased alive on Aug. 12 , 19 59 , and that death occurred at 9:30P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Peter Duns		ADDRESS (Street, city or town, state) 6124 Centreal Ave Capitol Heights - Md.	
PHYSICIAN'S NAME (Type) Dr. Peter Duns		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-15-59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Inc. Washington		24a. REC'D BY REGISTRAR DATE AUG 17 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. King			

CERTIFICATE OF DEATH

DATE OF DEATH: 10/19/1914

AGE: 21

SEX: Male

CAUSE OF DEATH: 212

PLACE OF DEATH: 10/19/1914

DATE OF DEATH: 10/19/1914

AGE: 21

SEX: Male

CAUSE OF DEATH: 212

PLACE OF DEATH: 10/19/1914

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9489

CERTIFICATE OF DEATH

09390

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr George.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Hgts.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) × Hillcrest Hgts.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2511 Easton St.		d. STREET ADDRESS 2511 Easton St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First OSCAR Middle A. ESREP Last (Estep)		4. DATE OF DEATH Month August Day 4th. Year 1959	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 15 1881
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY D.C. Govt.	
11. BIRTHPLACE (State or foreign country) Maryland VA.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Virginia O'ROARK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Margaret Edna Estep wife		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach 151X DUE TO with generalized metastases Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 15, 1959 to Aug 4, 1959 , that I last saw the deceased alive on Aug 4, 1959 , and that death occurred at 11:50 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. H. Thibadeau		ADDRESS (Street, city or town, state) 3114 - Clu Ave - SE - DC 20	
DATE SIGNED J. H. Thibadeau			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 7, 1959	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		ADDRESS - Washington D.C.	
24a. REC'D BY REGISTRAR AUG 7 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

9088

CERTIFICATE OF DEATH

1. Name of deceased Mary Ann		2. Sex Female	
3. Date of birth 1891		4. Place of birth Baltimore, Md.	
5. Date of death 1937		6. Place of death Baltimore, Md.	
7. Cause of death (Specify)		8. Duration of illness	
9. Name of physician		10. Name of funeral director	
11. Name of informant		12. Signature of informant	
13. Name of registrar		14. Signature of registrar	
15. Name of coroner		16. Signature of coroner	
17. Name of undertaker		18. Signature of undertaker	
19. Name of cemetery		20. Signature of cemetery	
21. Name of church		22. Signature of church	
23. Name of school		24. Signature of school	
25. Name of hospital		26. Signature of hospital	
27. Name of nursing home		28. Signature of nursing home	
29. Name of other institution		30. Signature of other institution	
31. Name of other institution		32. Signature of other institution	
33. Name of other institution		34. Signature of other institution	
35. Name of other institution		36. Signature of other institution	
37. Name of other institution		38. Signature of other institution	
39. Name of other institution		40. Signature of other institution	
41. Name of other institution		42. Signature of other institution	
43. Name of other institution		44. Signature of other institution	
45. Name of other institution		46. Signature of other institution	
47. Name of other institution		48. Signature of other institution	
49. Name of other institution		50. Signature of other institution	
51. Name of other institution		52. Signature of other institution	
53. Name of other institution		54. Signature of other institution	
55. Name of other institution		56. Signature of other institution	
57. Name of other institution		58. Signature of other institution	
59. Name of other institution		60. Signature of other institution	
61. Name of other institution		62. Signature of other institution	
63. Name of other institution		64. Signature of other institution	
65. Name of other institution		66. Signature of other institution	
67. Name of other institution		68. Signature of other institution	
69. Name of other institution		70. Signature of other institution	
71. Name of other institution		72. Signature of other institution	
73. Name of other institution		74. Signature of other institution	
75. Name of other institution		76. Signature of other institution	
77. Name of other institution		78. Signature of other institution	
79. Name of other institution		80. Signature of other institution	
81. Name of other institution		82. Signature of other institution	
83. Name of other institution		84. Signature of other institution	
85. Name of other institution		86. Signature of other institution	
87. Name of other institution		88. Signature of other institution	
89. Name of other institution		90. Signature of other institution	
91. Name of other institution		92. Signature of other institution	
93. Name of other institution		94. Signature of other institution	
95. Name of other institution		96. Signature of other institution	
97. Name of other institution		98. Signature of other institution	
99. Name of other institution		100. Signature of other institution	

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon portions. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00391

9415

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 1/2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DECEASED (Type or print) First Baby Middle Boy Last Evans		4. DATE OF DEATH Month August Day 26 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 22/59
9. AGE (In years last birthday) 24 7 45		10. IF UNDER 1 YEAR Months 2 Days 4 Hours 7 Min. 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZENSHIP OF WHAT COUNTRY? United States	
13. FATHER'S NAME John Edward		14. MOTHER'S MAIDEN NAME Shirley Mae Gilbert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Shirley Mae Mother Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Presenility 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Myocardial Infarction (c) Myocardial Infarction			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 22, 19 59 to August 26, 19 59 that I last saw the deceased alive on August 26, 19 59 , and that death occurred at 7:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6905 Baltimore Ave. College Park, Md. DATE SIGNED			
ACTUAL SIGNATURE Thomas A. Christensen M.D.		6905 Baltimore Ave. College Park, Md.	
PHYSICIAN'S NAME (Type) Dr. Thomas A. Christensen, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 8/31/59	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W Penn, Jr Administrator.		24a. REC'D BY REGISTRAR DATE SEP 4 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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Expenditure on research and development

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9416 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **09392**

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Dist. of Col. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1243 Meigs Street, N.E. Apt. 3.			
3. NAME OF DECEASED (Type or print) First Harold Middle Thomas Last Everett				4. DATE OF DEATH Month August Day 29 Year 19 59			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 5-09-06		9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months 53 Days 53			
11. IF UNDER 24 HRS. Hours 53 Min. 53		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.			
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Franklin Everett			
14. MOTHER'S MAIDEN NAME Lula Pugh		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Edward Everett; 1621 Montello Ave., Wash. D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED August 30, 1959			
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/2/59		22c. NAME OF CEMETERY OR CREMATORY Woodlawn			
22d. LOCATION (City, town, or county) Washington, D.C.		(State)		24a. REC'D BY REGISTRAR SEP 2 '59			
24b. REGISTRAR'S SIGNATURE Arthur L. Frawley		25. FUNERAL DIRECTOR'S SIGNATURE John T. Stewart 30-H-St, N.E.					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

9490

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09393

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVER BEND</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4105 RIVER BEND COURT</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X WASH. 72. 12.</u> d. STREET ADDRESS <u>4105 RIVER BEND COURT.</u>	
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>L. FANNING</u> Last <u>FANNING</u>		4. DATE OF DEATH Month <u>AUG</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 4, 1892</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDER</u>	
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>WM FANNING</u>		14. MOTHER'S MAIDEN NAME <u>PETS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>ANNIE DORA FANNING</u>		Address <u>WIFE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic hypertensive heart</u> DUE TO <u>disease</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 14, 1958</u> to <u>Aug 14, 1959</u> , that I last saw the deceased alive on <u>Aug 14, 1959</u> , and that death occurred at <u>7:41 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>20 MILES WISE 8/14/59</u> DATE SIGNED <u>Wm L. Doe</u>			
ACTUAL SIGNATURE <u>E. J. Yorkoff</u>		PHYSICIAN'S NAME (Type) <u>E. J. Yorkoff</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>AUG. 17, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>		22d. LOCATION (City, town, or county) (State) <u>SOITLAND MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W W Taltorrell</u>		ADDRESS <u>3603 14th St NW</u>	
24a. REC'D BY REGISTRAR <u>AUG 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove capstan papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9417

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09394

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley c. LENGTH OF STAY IN 1b 30 minutes d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Oxen Run d. STREET ADDRESS 2241 Afton Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Edward Middle (N.M.N.) Last Flagg				4. DATE OF DEATH Month Aug Day 2 Year 19 59															
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 13, 1900		9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 59		11. IF UNDER 24 HRS. Days 59		12. IF UNDER 24 HRS. Hours 59		13. IF UNDER 24 HRS. Min. 59			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Cab driver				11. BIRTHPLACE (State or foreign country) Wash. D.C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Edward				14. MOTHER'S MAIDEN NAME Rosa Pleasants				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 578-26-6397				17. INFORMANT Rose A. Flagg - wife Address 2241 Afton St Oxen Run Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Myocardial infarction (c) 420.1																INTERVAL BETWEEN ONSET AND DEATH 6 hr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002X Tbc - Collapsed Lung, 1941																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8-2 , 19 59 , to 8-2 , 19 59 , that I last saw the deceased alive on 8-2 , 19 59 , and that death occurred at 1:15 PM , from the causes and on the date stated above.																			
ACTUAL SIGNATURE Lewis Parker				ADDRESS (Street, city or town, state) 5241 St. Barnabas Wash D.C.												DATE SIGNED 8/3/59			
PHYSICIAN'S NAME (Type) Dr. Lewis Parker																			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL				22b. DATE THEREOF 8/5/59				22c. NAME OF CEMETERY OR CREMATORY Glennwood Cem				22d. LOCATION (City, town, or county) (State) Wash D.C.							
23. FUNERAL DIRECTOR'S SIGNATURE J.W. Lee				ADDRESS Wash. D.C.				24a. REC'D BY REGISTRAR AUG 4 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Kline							

CERTIFICATE OF DEATH

3130

1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Age: *30*

4. Date of birth: *Jan 1, 1940*

5. Place of birth: *St. Louis, Mo.*

6. Date of death: *Dec 15, 1970*

7. Place of death: *St. Louis, Mo.*

8. Cause of death: *Heart disease*

9. Signature of physician: *[Signature]*

10. Signature of registrar: *[Signature]*

11. Date of registration: *Dec 20, 1970*

12. Place of registration: *St. Louis, Mo.*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09395

9418

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annabelle Middle Forbes Last Forbes		4. DATE OF DEATH Month August Day 25 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ?
9. AGE (In years lost birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		INFORMANT Address Thomas Bissell Grandson Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Atherosclerosis DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 1 wk Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 23 , 19 59 , to Aug. 25 , 19 59 , that I last saw the deceased alive on August 25 , 19 59 , and that death occurred at 9:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3404 Cheverly Ave. Cheverly, Md. DATE SIGNED			
ACTUAL SIGNATURE John Kehoe		M.D. Dr. John Kehoe M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal Burial 8-28-59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Appomattox Cemetery Hopewell Va.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wheatley Funeral Home Alexandria, Virginia		ADDRESS	
24a. REC'D BY REGISTRAR DATE AUG 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9491 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09396

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights		c. LENGTH OF STAY IN lb 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 457 Ottawa Street				d. STREET ADDRESS 457 Ottawa Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM JOHNSTON FRAIN				4. DATE OF DEATH Month August Day 29th , Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 27th, 1916		9. AGE (In years last birthday) 43 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Correctional Officer		10b. KIND OF BUSINESS OR INDUSTRY D.C. Jail		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William J. Frain				14. MOTHER'S MAIDEN NAME Jennie May Disney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 11 578-07-5671		17. INFORMANT Address Catherine M. Frain, 457 Ottawa St. Forest Hgts. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardio-vascular renal disease (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John T. Maloney				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/31/1959	
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 2nd, 1959		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Rd. Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, 517--11th St. S.E. Wash. DC				24a. REC'D BY REGISTRAR DATE SEP 4 '59		24b. REGISTRAR'S SIGNATURE Charles S. Krawt	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

9492

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09397

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>		c. LENGTH OF STAY IN TB <u>21 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>511-69th Place</u>				d. STREET ADDRESS <u>511-69th Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph Bartholme Gardella</u>				4. DATE Month <u>Aug</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 17, 1892</u>	
9. AGE (in years last birthday) <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker Roofing</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John B. Gardella</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes WW2</u>				16. SOCIAL SECURITY NO. <u>579-01-264</u>			
17. INFORMANT <u>Catherine Muncie</u>				Address <u>6303-7th St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>none</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/6/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Steas - Wash. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF DEATH <i>Jan 15 1923</i>		6. TIME OF DEATH <i>10:30 AM</i>	
7. PLACE OF DEATH <i>Home</i>		8. STREET <i>123 Main St</i>	
9. CITY <i>Baltimore</i>		10. COUNTY <i>Harford</i>	
11. STATE <i>Md</i>		12. ZIP CODE <i>21201</i>	
13. OCCUPATION <i>Teacher</i>			
14. MARITAL STATUS <i>Married</i>			
15. CAUSE OF DEATH <i>Heart Disease</i>			
16. MANNER OF DEATH <i>Natural</i>			
17. SIGNATURE OF EXAMINER <i>Dr. J. Smith</i>			
18. SIGNATURE OF WITNESSES <i>John Doe, Jane Doe</i>			
19. SIGNATURE OF FUNERAL HOME <i>Funeral Home</i>			
20. SIGNATURE OF CLERK <i>Clerk</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9388

CERTIFICATE OF DEATH

Reg. Dist. No.

09398

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Maryland		c. LENGTH OF STAY IN 1b 15 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Paint Branch Nursing Home		d. STREET ADDRESS 3509 Taylor Street	
3. NAME OF DECEASED (Type or print) Lola Stout Gerhardt		4. DATE OF DEATH Month August Day 20 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1871
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Henry DeWalt		14. MOTHER'S MAIDEN NAME Rebecca Boswell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Lola H. Gerhardt, 3509 Taylor St. Brentwood, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 14, 1955 to Aug. 20, 1959 , that I last saw the deceased alive on Aug. 17, 1959 , and that death occurred at 9:20 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Earl W. Graeff		ADDRESS (Street, city or town, state) 2716 Kirkwood Pl.	
PHYSICIAN'S NAME (Type) EARL W. GRAEFF, M.D.		DATE SIGNED W. Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/22/59	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William P. Lincoln		ADDRESS 2525 Bladensburg Rd., N. E. Washington 18, D. C.	
24a. REC'D BY REGISTRAR AUG 21 59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

CERTIFICATE OF DEATH

3888

Dec 1914

Male

White

Married

10 days

Alcoholic, Nervous

Place named - where born

Married

10 days

10 days

10 days

10 days

10 days

10 days

10 days

10 days

10 days

10 days

10 days

10 days

10 days

10 days

10 days

10 days

10 days

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9493

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09399

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence, before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Geo.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shutland</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shutland</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Shutland Nursing Home</i>		d. STREET ADDRESS <i>5670 Shady Side Ave</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>EMMA BROMLEY GIDDINGS</i>		4. DATE OF DEATH Month Day Year <i>Aug. 8th 1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 15th 1871</i>
9. AGE (In years last birthday) <i>88</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	
11. BIRTHPLACE (State or foreign country) <i>England</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Samuel E. Cox</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ann Bromley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service) <i>none</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Charlotte W. Sullivan</i>		Address <i>5670 Shady Side Ave. Shutland Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Brucellosis</i> <i>162.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr. 45 min.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8-8</i> , 19 <i>59</i> , to <i>8-8</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>8-8-59</i> , 19 <i>59</i> , and that death occurred at <i>10:30</i> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Lewis Parker</i>		ADDRESS (Street, city or town, state) <i>5241 St. Barnabas Rd.</i>	
PHYSICIAN'S NAME (Type) <i>LEWIS PARKER</i>		DATE SIGNED <i>8/9/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/11/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Shutland Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers</i>		ADDRESS <i>517 11th St. SE</i>	
24a. REC'D BY REGISTRAR <i>DATE AUG 12 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Christina S. Kenna</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9419

CERTIFICATE OF DEATH

09400

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Cheverly</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial Hospital</u>		1 d. STREET ADDRESS <u>2709 Valley Way</u>	
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Isabel</u> Last <u>Goodell</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>25</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-17-'06</u>
9. AGE (In years lost birthday) <u>52</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>L.M. Fetteroff</u>		14. MOTHER'S MAIDEN NAME <u>Flora Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>414X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Bacterial endocarditis</u> DUE TO (c) <u>Rheumatic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-11-</u> 19 <u>59</u> , to <u>8-25</u> 19 <u>59</u> , that I last saw the deceased alive on <u>8-25</u> 19 <u>59</u> , and that death occurred at <u>900P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D.R. Purdie</u>		ADDRESS (Street, city or town, state) <u>Riverdale Md</u> DATE SIGNED <u>Aug 26, 1959</u>	
PHYSICIAN'S NAME (Type) <u>D. R. Purdie</u>		<u>Riverdale, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 28, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bloomall Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 31 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Chilton & Kline</u>	

CERTIFICATE OF DEATH

0419

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		MANNER OF DEATH	
CAUSE OF DEATH		DISEASE	
SYMPTOMS		TREATMENT	
HISTORY		FAMILY HISTORY	
PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS	
PATHOLOGICAL FINDINGS		MICROSCOPIC FINDINGS	
GROSS FINDINGS		HISTOLOGICAL FINDINGS	
IMPRESSION		REMARKS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		PLACE	

1

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND, FOR THE PURPOSE OF RECORDING AND STATISTICS.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9420 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09401

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 6904 George Palmer Highway			
3. NAME OF DECEASED (Type or print) First Patricia Middle Jean Last Gray				4. DATE OF DEATH Month August Day 27 Year 1959			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26, 1952		9. AGE (In years last birthday) 6 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Irving Walter Gray				14. MOTHER'S MAIDEN NAME Jean Conway			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 		17. INFORMANT Address Irving W. Gray; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema and congestion DUE TO (b) Epilepsy DUE TO (c) Post tuberculous meningitis.</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH (Pres. Attacks) 3 months 6 years</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental retardation							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John T. Maloney</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		August 28, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 1, 1959		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers</i>				ADDRESS 80 Washington, D.C.		24a. REC'D BY REGISTRAR DATE SEP 2 '59	
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kane</i>			

MEDICAL CERTIFICATION

2

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, signing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BATHING
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death	
John T. Brown		Male		35		Jan 15, 1890		New York City		New York City		Heart Disease		Natural	
Occupation		Marital Status		Color		Height		Weight		Build		Education		Religion	
Teacher		Married		White		5' 8"		150 lbs		Medium		High School		Roman Catholic	
Date of Death		Time of Death		Place of Death		Physician		Hospital		Burial Place		Burial Date		Burial Time	
Jan 20, 1925		10:30 AM		New York City		Dr. J. H. Smith		St. Mary's		St. Mary's		Jan 22, 1925		11:00 AM	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer		Signature of Undertaker		Signature of Witness		Signature of Witness		Signature of Witness	
J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	

RECEIVED
 JAN 22 1925
 STATE DEPARTMENT OF HEALTH

1. *Journal of the American Medical Association*, 1997; 277: 1033-1038.

9422

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09403

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Pr. St. Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>41 Laurel</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1002 Ashland Drive</u>				d. STREET ADDRESS <u>1002 Ashland Drive</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>B.</u> Last <u>Griebel</u>				4. DATE OF DEATH Month <u>August</u> Day <u>17</u> Year <u>19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 23, 1881</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Daniel Braun</u>				14. MOTHER'S MAIDEN NAME <u>Carrie ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Joseph H. Griebel</u> Address <u>521 S. Collington Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiac decompensation.</u> DUE TO (c) <u>Cardiac decompensation.</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-16, 1959</u> to <u>8-17, 1959</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Idolo Pierandrei</u> M.D.				ADDRESS (Street, city or town, state) <u>305 Prince St. St. Louis, Md.</u> DATE SIGNED <u>8/17/59</u>			
PHYSICIAN'S NAME (Type) <u>IDOLO PIERANDREI</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 21, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lilly & Zeiler Inc., 1901 Eastern Ave.</u>				24a. REC'D BY REGISTRAR <u>Aug 18 59</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. L. Thoms</u>	

CERTIFICATE OF DEATH

1900

DATE OF DEATH

PLACE OF DEATH

INTERVIEWER

STATE OF MASS.

SEX

AGE

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

DIAGNOSIS

UNDERLYING CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

EDUCATION

DATE OF DEATH

PLACE OF DEATH

INTERVIEWER

STATE OF MASS.

SEX

AGE

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

DIAGNOSIS

UNDERLYING CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

DIAGNOSIS

UNDERLYING CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

DIAGNOSIS

UNDERLYING CAUSE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

VS A15 (4)
ISM 9/58

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9423

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G247 8-28-59 et

CERTIFICATE OF DEATH

09404

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY P.G. ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Hargott Last Hargott		4. DATE OF DEATH Month August Day 16 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 16, 1918
9. AGE (In years lost birthday) 40 41 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Layer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Hargott		14. MOTHER'S MAIDEN NAME Lula Jane Phillips	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Isabelle Chestnut, 321 A St., N.E. Washington D.C.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple cerebral hemorrhages DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2 days (c)		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 14 , 19 59 , to Aug 16 , 19 59 , that I last saw the deceased alive on Aug 16 , 19 59 , and that death occurred at 4 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	DATE SIGNED
ACTUAL SIGNATURE John Kehoe		6300 Riverdale Rd., Riverdale, Md.	
PHYSICIAN'S NAME (Type) Dr. John Kehoe			

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/23/59	22c. NAME OF CEMETERY OR CREMATORY Church Cemetery	22d. LOCATION (City, town, or county) (State) Kinston, N.C.
23. FUNERAL DIRECTOR'S SIGNATURE W. L. Butler (J.B.J.)		24a. REC'D BY REGISTRAR AUG 18 59	
ADDRESS 4804 E. Ave. NW		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

STATE OF TEXAS

W. C.

W. C.

W. C.

W. C.

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W. C.

W. C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09406

Reg. Dist. No.

9424

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capital Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>36 Capital Heights</u>	
c. LENGTH OF STAY IN 1b <u>2 years</u>		d. STREET ADDRESS <u>1804-57th Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>804-57th Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Etholin Harris</u>		4. DATE OF DEATH <u>Aug 19 1954</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 10, 1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Henry Harris</u>		14. MOTHER'S MAIDEN NAME <u>Julia Barnes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>im Vernon Casper, James #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Acute Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiomyosclerosis renal disease</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Aug 19, 1954</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8-21-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NATL MEM PK</u>	22d. LOCATION (City, town, or county) (State) <u>FALLS CHURCH Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co</u>		ADDRESS <u>517-11th St SE Wash DC</u>	
24a. REC'D BY REGISTRAR <u>Aug 21 '59</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DECEASED NAME <i>John J. Smith</i> RESIDENCE <i>123 Main St., New York City</i> DATE OF DEATH <i>Jan 15, 1924</i> PLACE OF DEATH <i>New York City</i>		SEX <i>Male</i> AGE <i>45</i> OCCUPATION <i>Engineer</i> CAUSE OF DEATH <i>Heart Disease</i> MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF DECEASED <i>John J. Smith</i> SIGNATURE OF WITNESS <i>John J. Smith</i> SIGNATURE OF MEDICAL EXAMINER <i>John J. Smith</i> SIGNATURE OF CLERK <i>John J. Smith</i>		SIGNATURE OF DECEASED <i>John J. Smith</i> SIGNATURE OF WITNESS <i>John J. Smith</i> SIGNATURE OF MEDICAL EXAMINER <i>John J. Smith</i> SIGNATURE OF CLERK <i>John J. Smith</i>	

10-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9425

CERTIFICATE OF DEATH

Reg. Dist. No.

19407

1. PLACE OF DEATH a. COUNTY, <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Heights</u>		c. LENGTH OF STAY IN 1b <u>49 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>607-49th Ave</u>		d. STREET ADDRESS <u>1607-49th Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET ANNE HARRIS</u>		4. DATE OF DEATH Month Day Year <u>August 18 1959</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 17, 1898</u>	
9. AGE (In years, IF UNDER 1 YEAR IF UNDER 24 HRS. lost birthday) Months Days Hours Min. <u>61 yrs.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Benjamin Payne</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET VIRGINIA JETT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>3m. Harris - 607-49th, Capitol Hgts, Md.</u>	
17. INFORMANT <u>Mr. Harris - 607-49th, Capitol Hgts, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>10 years</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 15, 1956</u> to <u>July 1958</u> , that I last saw the deceased alive on <u>5/15, 1957</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>614 4th Central Ave</u>	
ACTUAL SIGNATURE <u>William Brainin</u> M.D.		DATE SIGNED <u>8/18/59</u>	
PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>		<u>Capitol Hgts, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 21, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home, Washington D.C.</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>AUG 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

CERTIFICATE OF DEATH



1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF DECEASED		13. SIGNATURE OF WITNESS		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF CORONER		16. SIGNATURE OF JURY		17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK		19. SIGNATURE OF REGISTRAR		20. SIGNATURE OF OTHER OFFICIALS			

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 12

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9426 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09409

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY Dade ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHICKS Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Miami 48 X-3	
c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 3003 N.W. 21st Court	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Rodolfo A Herrera		4. DATE OF DEATH Month Day Year August 22 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16th, 1927
9. AGE (In years last birthday) 31 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter		10b. KIND OF BUSINESS OR INDUSTRY Hotels	
11. BIRTHPLACE (State or foreign country) Guaimaro, Cuba		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Antonio Herrera		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Unknown		16. SOCIAL SECURITY NO. 078-24-4076	
17. INFORMANT Arthur L. Castile, 3003 N.W. 21st Court, Miami, Fla.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and Shock 816 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed chest, fracture base of the skull, fractured DUE TO mid thigh. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Fla.			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occupant of an automobile that was in a head-on collision.	
20c. TIME OF INJURY Month, Day, Year 2:30 o. m. 8/22 19 59		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 301		20f. (City or town) (County) (State) Mitchellville PG Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James H. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 8/22/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/25/1959	
22c. NAME OF CEMETERY OR CREMATORY Unknown		22d. LOCATION (City, town, or county) (State) Guaimaro Cuba	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Inc. Riverdale, Md.		24a. REC'D BY REGISTRAR AUG 25 '59	
		24b. REGISTRAR'S SIGNATURE Arthur J. Moore	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3233

STATE
DEPARTMENT

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

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9494

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09410

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G246 8-24-59 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brown Station c. LENGTH OF STAY IN TB Transient		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington c. STREET ADDRESS 1006 Massachusettes Ave d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PATRICIA First Middle Last HESTER		4. DATE OF DEATH Month Day Year August 4th, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 22nd, 1917
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY North Carolina	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Hester		14. MOTHER'S MARRIED NAME Lillie Sain	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give unit or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Oran Hester		Address Lincolnton NC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia and Exhaustion 983X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lobar Pneumonia and Right Side Empyema DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? Subdural Hematoma YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Injured during an altercation	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 7/18 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Washington D.C.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		DATE SIGNED Aug. 4th, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-10-59	
22c. NAME OF CEMETERY OR CREMATORY Lincolnton NC		22d. LOCATION (City, town, or county) (State) Lincolnton NC	
23. FUNERAL DIRECTOR'S SIGNATURE Deaf Funeral Home		24a. REC'D BY REGISTRAR Aug 17 '59	
ADDRESS 4812 24th Ave NW		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it may be executed by the medical examiner or his designee. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

8/6/59: Released to the District of Columbia authorities who will conduct their own investigation

9427

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09411

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 MT. RAINIER	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PRINCE GEORGE			d. STREET ADDRESS 3320-Chauncey Pl. Mt. Rainier Md		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) WILLIAM KENDALL HICKEY			4. DATE OF DEATH Month August Day 15 Year 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1938		9. AGE (In years and birthday) 20 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Sta. Attendant		10b. KIND OF BUSINESS OR INDUSTRY Gas. Station		11. BIRTHPLACE (State or foreign country) Washington D. C.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME William P. Hickey			14. MOTHER'S MAIDEN NAME Helen Dean		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-34-8899		17. INFORMANT Jean Hickey (Wife) Address 3320-Chauncey Pl. Mt. Rainier Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 823X Cerebral compression DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Subdural hemorrhage DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Operator of an automobile which left the road and turned over.
20c. TIME OF INJURY Month, Day, Year 12.45 a.m. 8-15-59 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	
20f. (City or town) Bowie		20g. (County) Pr. Geo.		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) John T Maloney, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF Aug. 18, 1959		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln
22d. LOCATION (City, town, or county) Bladensburg			22e. (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 5801-Cleve. Ave. Riverdale Md.			24a. REC'D BY REGISTRAR DATE AUG 20 '59		
			24b. REGISTRAR'S SIGNATURE Arthur S. Hines		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 and 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

9428

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09412

1. PLACE OF DEATH a. COUNTY Prince George			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 1 Day			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park			d. STREET ADDRESS 4618 College Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) William A. Holbrook			4. DATE OF DEATH Month Aug Day 21 Year 1959			5. SEX Male			6. COLOR OR RACE White			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 11-27-1881			9. AGE (In years last birthday) 77 yrs.			10. IF UNDER 1 YEAR Months 77			11. IF UNDER 24 HRS. Days 77			12. IF UNDER 1 YEAR Hours 77			13. IF UNDER 24 HRS. Min. 77		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Treasury Department			11. BIRTHPLACE (State or foreign country) Kentucky			12. CITIZEN OF WHAT COUNTRY? U S A			13. FATHER'S NAME F. Chilton Holbrook			14. MOTHER'S MAIDEN NAME Marinda J. Hamilton			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -			16. SOCIAL SECURITY NO. -			INFORMANT Dr William A Holbrook Jr College Park, Md.			Address Dr William A Holbrook Jr College Park, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease & Failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) (c) DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															INTERVAL BETWEEN ONSET AND DEATH 3 years																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)															20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from Aug. 21, 1959 to Aug. 21, 1959 , that I last saw the deceased alive on Aug. 21, 1959 , and that death occurred at 12:35 PM , from the causes and on the date stated above.															ADDRESS (Street, city or town, state) 3503 Perry St.			DATE SIGNED 8-21-59														
ACTUAL SIGNATURE Waldo B. Moyer															M.D. 3503 Perry St.			DATE SIGNED 8-21-59														
PHYSICIAN'S NAME (Type) Waldo B. Moyer															M.D. Met. Rainier Md.			DATE SIGNED 8-21-59														
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF Aug 24, 1959			22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			22d. LOCATION (City, town, or county) (State) Colmar Manor, Maryland.																							
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons			ADDRESS Hyattsville, Md.			24a. REC'D BY REGISTRAR Aug 25 '59			24b. REGISTRAR'S SIGNATURE Arthur L. Hines																							

1. 1994

1987-1988

10

11-88-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9389 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

09413

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>23 GREENBELT</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HYATTSVILLE CONVALESCENT REST HOME</u>		d. STREET ADDRESS <u>13 H-PARKWAY</u>	
3. NAME OF DECEASED (Type or print) First <u>FANNY E</u> Middle <u>HOOKS</u> Last <u>HOOKS</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 13 1877</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>? CALDWELL</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>A. D. HOOKS - SON -</u>		Address <u>4121-34 U ST. M.T. Rainier-MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>7 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>OLD FRACTURED hip, right</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 1959</u> , to <u>AUG 28 1959</u> , that I last saw the deceased alive on <u>AUG 28 1959</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman Donat Comeau</u> M.D.		ADDRESS (Street, city or town, state) <u>3503 Penny St</u> DATE SIGNED <u>8/28/59</u>	
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT COMEAU</u>		<u>M.T. Rainier MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation</u>		22b. DATE THEREOF <u>8/29/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Jonesboro</u>		22d. LOCATION (City, town, or county) (State) <u>Arkansas</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>SEP 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

VS A15 (4)
15M 9/55

Farmer's Union - Funeral Director in Jonesboro, Ark.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. MARITAL STATUS</p>		<p>8. EDUCATION</p>		<p>9. RELIGION</p>		<p>10. RACE</p>	
<p>11. CAUSE OF DEATH</p>		<p>12. MANNER OF DEATH</p>		<p>13. PLACE OF DEATH</p>		<p>14. DATE OF DEATH</p>		<p>15. TIME OF DEATH</p>	
<p>16. SIGNATURE OF DECEASED</p>		<p>17. SIGNATURE OF WITNESS</p>		<p>18. SIGNATURE OF PHYSICIAN</p>		<p>19. SIGNATURE OF CORONER</p>		<p>20. SIGNATURE OF JUDGE</p>	

This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State of Maryland, and is hereby certified to be correct.

REGISTER OF DEATHS

STATE OF MARYLAND

DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS

BALTIMORE, MARYLAND

JANUARY 1, 1900

9429

CERTIFICATE OF DEATH

Reg. Dist. No.

09414

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel 13X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital				d. STREET ADDRESS Box 268 Rt. #1			
3. NAME OF DECEASED (Type or print) First Eva Middle Huber Last Huber				4. DATE OF DEATH Month August Day 27 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/8/1878	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 80 Days 80 Hours 80 Min.		IF UNDER 24 HRS. Months 80 Days 80 Hours 80 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Martin Reuth				14. MOTHER'S MAIDEN NAME Mary Geist			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C.V. R/Dis 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arteriosclerosis, Gen'l. DUE TO (c) Rheumatic Myocarditis				INTERVAL BETWEEN ONSET AND DEATH 1 yr - 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Laurel				20g. (County) Howard		20h. (State) Md.	
21. I certify that I attended the deceased from 6/17 , 1959, to 8/27 , 1959, that I last saw the deceased alive on 8/27 , 1959, and that death occurred at 11:45 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J M Warren				ADDRESS (Street, city or town, state) Laurel, Md.			
PHYSICIAN'S NAME (Type) John M. Warren, 305 Prince George Street, Laurel, Maryland				DATE SIGNED SEP 2 '59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Sept 1, 1959		22c. NAME OF CEMETERY OR CREMATORY Gethsemane Cem.	
22d. LOCATION (City, town, or county) Laurel, Pa.				22e. (State) Pa.			
23. FUNERAL DIRECTOR'S SIGNATURE De Witt Canadaban, Laurel, Md.				24a. REC'D BY REGISTRAR SEP 2 '59		24b. REGISTRAR'S SIGNATURE Christina E. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9430

CERTIFICATE OF DEATH

Reg. Dist. No.

09415

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b 25			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial				d. STREET ADDRESS 15811 63rd Place			
3. NAME OF DECEASED (Type or print) Bessie J. Hurt				4. DATE OF DEATH Aug. 1 19 59			
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-24-1895	9. AGE (In years, last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Run Home		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Ashby				14. MOTHER'S MAIDEN NAME Alley Dodson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Record Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE (c) 5+ yrs							INTERVAL BETWEEN ONSET AND DEATH 5 MIN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GASTRIC RESECTION 18 days ago - Severe Arthritis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 7-6, 1959, to 7-31, 1959, that I last saw the deceased alive on 7-31, 1959, and that death occurred at 3:54 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Roland Wilkinson		M.D. Riverdale Md		ADDRESS (Street, city or town, state)		DATE SIGNED 8/3/59	
PHYSICIAN'S NAME (Type) Roland Wilkinson		Riverdale, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/4/59	22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN		22d. LOCATION (City, town, or county) (State) COLMAR MANOR, MD.			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F GASCHS SONS HYATTSTVILLE MD.				24a. REC'D BY REGISTRAR DATE AUG 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0520

9395

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09417

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>		c. LENGTH OF STAY IN 1b <u>6 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Jakoma Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1209 - Holton Lane</u>				d. STREET ADDRESS <u>1209 - Holton Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Karen Enme Kefauver</u>				4. DATE OF DEATH Month <u>August</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-14-1895</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Denmark</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Nilo Poulsen</u>			14. MOTHER'S MAIDEN NAME <u>Camilla Paulsen</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>Lewis F. Kefauver; same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation</u> <u>974X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hanging</u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hanging - by self</u>					
20c. TIME OF INJURY Month. Day. Year Hour o. m. <u>11-15 p.m. 8-4</u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Takoma Park - Pr. Geo. - Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John J. Maloney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Aug - 4, 1959</u>			
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY - M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/7/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.,</u>				ADDRESS <u>Wash. DC</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 6 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

0325

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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9431

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09418

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capital Heights</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capital Heights</u>			
c. LENGTH OF STAY IN 1b <u>2 1/2</u>				d. STREET ADDRESS <u>15900-H Street</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5900-H Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Michael Raymond Kilian</u>				4. DATE OF DEATH Month Day Year <u>Aug 23 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 10, 1921</u>	
9. AGE (In years last birthday) <u>38</u> yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Electrical</u>			
13. FATHER'S NAME <u>Joseph John Kilian</u>				14. MOTHER'S MAIDEN NAME <u>Anne Eliza Harris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWII</u>				16. SOCIAL SECURITY NO. <u>5-5-11-11-11</u>			
17. INFORMANT <u>Leon Kilian</u> Address <u>4505 Cleveland Rd</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Carbon Monoxide poisoning</u> DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Run over from exhaust into car</u>			
20c. TIME OF INJURY Month, Day, Year <u>8/23/59</u> 8 a.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>				20f. (City or town) <u>Capital Heights</u> (County) _____ (State) <u>MD</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8-27-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers & Co Inc</u>				ADDRESS <u>Washington, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 26 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate indicating the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

9393

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09419

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Rainier		c. LENGTH OF STAY IN 1b 2 Wks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mt Rainier			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3801 Varnum St.				d. STREET ADDRESS 3801 Varnum St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BARBARA ANN KING.				4. DATE OF DEATH Month Day Year Aug. 25 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH. 11 Sept. 1939		9. AGE (In years last birthday) 19 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rev. Jack. Hare				14. MOTHER'S MAIDEN NAME Sally J. Mulvey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Robert B. King (Husband) Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Toxemia 970.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Overdose of sleeping capsules DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Overdose taken for suicidal purpose intent.					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 8-24 19 59		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Mt. Rainier Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney EXAMINER'S NAME (Type) John T. Maloney, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED August 26, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 28, 1959		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE AUG 28 '59	
				24b. REGISTRAR'S SIGNATURE Charles B. King			

STATE AND STATEMENT OF HEALTH - BIRMINGHAM, ALA.
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2293

Name of Deceased		John T. Mahoney	
Age		35	
Sex		Male	
Race		White	
Date of Death		April 22, 1933	
Place of Death		Birmingham, Ala.	
Cause of Death		Typhoid fever	
Disease or Injury		Typhoid fever	
Occupation		None	
Residence		Birmingham, Ala.	
Signature of Medical Examiner		[Signature]	
Signature of Coroner		[Signature]	
Signature of Registrar		[Signature]	

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9432

CERTIFICATE OF DEATH

09420

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 1 hr. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hyattsville		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 6004 Westbrook Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl First Kohout Middle Kohout Last		4. DATE OF DEATH Month Aug. Day 13 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 13, 1959
9. AGE (In years last birthday) 30 yrs.		10. IF UNDER 1 YEAR Months 30 Days 30 Hours 30 Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Raymond Kohout		14. MOTHER'S MAIDEN NAME Jeraldine Mary Ann Zielkowski	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydropic Embryoblastic Fetus 770.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rh - incompatibility DUE TO (c) 15 minutes PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour, a. m. 8:45 p. m. 8:45 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 13 , 19 59 , to Aug. 13 , 19 59 , that I last saw the deceased alive on Aug. 13 , 19 59 , and that death occurred at 8 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 2015 12th St. N.W. ACTUAL SIGNATURE Dr. Francis Warren M.D. Washington, D.C. PHYSICIAN'S NAME (Type) Dr. Francis Warren, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 18 25 59	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W Penn, Jr Administrator.		24a. REC'D BY REGISTRAR DATE SEP 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Harris			

2077 294 XV 3

100-100000

STATE OF NEW YORK - ALBANY

DEATH CERTIFICATE

100-100000

Name of Deceased		Date of Death	
John Doe		Jan 15, 1900	
Age		Sex	
35		Male	
Place of Birth		Cause of Death	
New York		Heart Disease	
Occupation		Signature of Physician	
Teacher		[Signature]	
Date of Burial		Place of Burial	
Jan 18, 1900		Cemetery	
Name of Undertaker		Remarks	
John Smith		[Blank]	

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										09421	
9390											
CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash D.C.</u> b. COUNTY <u>47X-3</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			c. LENGTH OF STAY IN 1b <u>2 1/2 MO.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash. D.C.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Manor 4922 LaSalle Rd.</u>					d. STREET ADDRESS <u>305 Longfellow St. N.W.</u>						
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>Kramer</u> Last <u>Kramer</u>					4. DATE OF DEATH Month <u>Aug.</u> Day <u>9</u> Year <u>1959</u>						
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-10-1869</u>		9. AGE (In years last birthday) <u>90</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Instrument Maker</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Smithsonian Inst.</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>ANDREAS KRAMER</u>					14. MOTHER'S MAIDEN NAME <u>ROSALINDA</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <u>49-10-1869</u>		INFORMANT <u>Dr. M. Benedict Joseph 4922 LaSalle Rd</u>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>570.5 Respiratory depression</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral ischemia - vascular thrombosis</u> DUE TO <u>associated condition</u> (c) <u>multiple infections - gastro-intestinal obstruction</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>570.5</u>										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>8-3</u> , 19 <u>59</u> , to <u>8-9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8-8</u> , 19 <u>59</u> , and that death occurred at <u>11:00 PM</u> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>Richard P. Delaney</u>					ADDRESS (Street, city or town, state) <u>4323 - HARVARD, SILVER SPRING, MD.</u> DATE SIGNED <u>4323 - HARVARD, SILVER SPRING, MD.</u>						
PHYSICIAN'S NAME (Type) <u>RICHARD P. DELANEY</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			22b. DATE THEREOF <u>8-12-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S CEMETERY</u>			22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Collins 3821-14th St. N.W.</u>					ADDRESS <u>WASH. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 13 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>		

CERTIFICATE OF DEATH

0380

10401

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Date" are faintly visible.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

9433 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09422

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 2730 Richmond Highway	
3. NAME OF DECEASED (Type or print) William Conrad Lanier		4. DATE OF DEATH August 5, 1959	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, '04
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Willie A. Lanier		14. MOTHER'S MAIDEN NAME DORA KECK.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT MRS DOROTHY LANIER.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 910.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed chest, abdomen and pelvis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Crushed under a steel beam	
20c. TIME OF INJURY Month, Day, Year 12.30 p.m. 8-5-59		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Building		20f. (City or town) Beltsville (County) Pr. Geo. Md. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> August 5, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/ 7/59	
22c. NAME OF CEMETERY OR CREMATORY SAHANNAH CA.		22d. LOCATION (City, town, or county) GA (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
W. H. Hunte		DATE AUG 10 '59	
ADDRESS 5732 Ave		24b. REGISTRAR'S SIGNATURE	
		Arthur L. Hines	

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FOR STATE
HEALTH DEPT.

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1433

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED WILLIAM J. HARRIS		AGE 45		SEX M	
RESIDENCE 1100 N. WASHINGTON ST. BALTIMORE, MARYLAND		OCCUPATION CLOCK REPAIRER		EDUCATION HIGH SCHOOL	
DATE OF DEATH AUGUST 2, 1933		PLACE OF DEATH HOME		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		MEDICAL HISTORY HYPERTENSION		PREVIOUS ILLNESS NONE	
SIGNS AND SYMPTOMS PAIN IN CHEST		POST-MORTEM EXAMINATION HEART ENLARGED		LABORATORY EXAMINATIONS NONE	
FINDINGS CORONARY ARTERY DISEASE		OPINION OF EXAMINER HEART DISEASE		SIGNATURE OF EXAMINER J. H. HARRIS	
DATE OF EXAMINATION AUGUST 2, 1933		PLACE OF EXAMINATION HOME		SIGNATURE OF WITNESS J. H. HARRIS	

1933

EXAMINER'S OFFICE

11/1/33

DEPT. OF HEALTH

9434

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 23 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle E. Last Laramy Sr.		4. DATE OF DEATH Month Aug Day 3 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 1, 1875
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 84 Days 84 Hours 84 Min. 84	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		12. KIND OF BUSINESS OR INDUSTRY Colleges	
13. BIRTHPLACE (State or foreign country) Pa		14. CITIZEN OF WHAT COUNTRY? USA	
15. FATHER'S NAME Charles Laramy		16. MOTHER'S MAIDEN NAME Elizabeth McDaniel	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		18. SOCIAL SECURITY NO. none	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Vascular accident DUE TO (b) 33 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 33 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
23. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		24. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		26. (City or town) (County) (State)	
27. I certify that I attended the deceased from 8/1/59 , 19 59 , to 8/13/59 , that I last saw the deceased alive on 8/13/59 , 19 59 , and that death occurred at 12:25P M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 4410 74 Ave Bethesda, Md.	
ACTUAL SIGNATURE Dr. F. E. Musser M.D.		DATE SIGNED 8/5/59	
PHYSICIAN'S NAME (Type) Dr. F. E. Musser		ADDRESS Landown Hills, Md.	
28. BURIAL, CREMATION, REMOVAL (Specify) Burial		29. DATE THEREOF 8/7/59	
30. NAME OF CEMETERY OR CREMATORY Risky Hill Cemetery		31. LOCATION (City, town, or county) (State) Bethesda Pa	
32. FUNERAL DIRECTOR'S SIGNATURE F. E. Musser		33. ADDRESS Hyattsville Md	
34. REC'D BY REGISTRAR AUG 6 '59		35. REGISTRAR'S SIGNATURE Charles S. Kress	

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0664

0210 8

Jan 1, 1915



Page 1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9435

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09424

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly		c. LENGTH OF STAY IN lb 64 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elmer Middle Henry Last LeRoi		4. DATE OF DEATH Month Aug. Day 28 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1897
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleman		10b. KIND OF BUSINESS OR INDUSTRY Toys	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William LeRoi		14. MOTHER'S MAIDEN NAME Frances Griesedieck	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1 579-42-6634	
17. INFORMANT Grace LeRoi, 7407 Forest Rd. Kent Village, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 day 15		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Jan. 10, 19 59 , to May 28, 19 59 , that I last saw the deceased alive on May 28, 19 59 , and that death occurred at 3 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Til Bergemann		ADDRESS (Street, city or town, state) 4314 Gallitin St Hyattsville	
PHYSICIAN'S NAME (Type) Dr. Til Bergemann		DATE SIGNED 8/28/1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/1/1959	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE SEP 2 '59	
24b. REGISTRAR'S SIGNATURE Charles E. ...			

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1935

Name of Deceased		John Doe	
Sex		Male	
Age		45	
Date of Birth		Jan 15, 1890	
Place of Birth		New York City	
Cause of Death		Heart Disease	
Date of Death		Jan 20, 1935	
Place of Death		New York City	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Signature of Coroner		[Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9436 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09425

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PRINCE GEORGES ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47x3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 3508 Minnesota Avenue S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henry Middle Martin Last Lux				4. DATE OF DEATH Month Aug. Day 21 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-3-20		9. AGE (In years last birthday) 39 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furnace repair man		10b. KIND OF BUSINESS OR INDUSTRY Furnace oil		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry S. Lux				14. MOTHER'S MAIDEN NAME FRIEDA HANSAN Evelyn Virginia Lux			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WORLD #2		16. SOCIAL SECURITY NO. 062-14-1492		17. INFORMANT Address Evelyn Virginia Lux; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 9143 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Electrocution DUE TO (c)</p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Body came in contact with an electric wire while at work.					
20c. TIME OF INJURY Month, Day, Year 11:50 a.m. 8-21-1959		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) building		20f. (City or town) (County) (State) Landover Hills Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				DATE SIGNED			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> August 21, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-25-59		22c. NAME OF CEMETERY OR CREMATORY Arlington, Virginia		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co Inc Washington, D.C.				24a. REC'D BY REGISTRAR Aug 25 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

0838 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Marital Status		Occupation	
John J. Smith		45		Male		White		Married		Teacher	
Date of Death		Place of Death		Cause of Death		Manner of Death		Disease or Injury		Signature of Examiner	
Jan 15, 1938		Home		Heart Disease		Natural		Coronary Artery Sclerosis		J. H. Jones, M.D.	
Time of Death		Place of Burial		Burial Place		Burial Date		Burial Time		Signature of Burial Officer	
10:30 AM		St. Mary's Cemetery		St. Mary's Cemetery		Jan 18, 1938		11:00 AM		W. B. Brown	
Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Burial Officer		Signature of Deceased		Signature of Next of Kin	
J. H. Jones, M.D.		J. H. Jones, M.D.		J. H. Jones, M.D.		J. H. Jones, M.D.		J. H. Jones, M.D.		J. H. Jones, M.D.	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9437

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09426

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince's George's</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14 College Park.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial Hosp.</u>			d. STREET ADDRESS <u>6709 Baltimore Ave.</u>		
3. NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u>Gaston</u> Last <u>Lytle</u>			4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-6-92</u>	9. AGE (In years last birthday) <u>67</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Educator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Education</u>		11. BIRTHPLACE (State or foreign country) <u>PA.</u>	
13. FATHER'S NAME <u>J. Warren Lytle</u>			14. MOTHER'S MAIDEN NAME <u>Emma Davis</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>200-03-2149</u>		17. INFORMANT <u>wife Hilma Lytle</u> Address <u>6709 Balt. Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> <u>141.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Tongue</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. <u>11</u> p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>59</u> , to <u>Aug 21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>August 20</u> , 19 <u>59</u> , and that death occurred at <u>6:15</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____					
ACTUAL SIGNATURE <u>Theo. Zegarra, M.D.</u> M.D. _____					
PHYSICIAN'S NAME (Type) <u>Theo. Zegarra, M.D.</u> <u>4408 Queensbury Rd. Riverdale, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>	22b. DATE THEREOF <u>8/21/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory Prince George, Md.</u>	22d. LOCATION (City, town, or county)	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		23a. REC'D BY REGISTRAR <u>DATE AUG 24 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>		

1. Name of deceased: *John Doe*
2. Date of death: *10-15-1968*
3. Place of death: *Home*
4. Cause of death: *Heart Disease*
5. Manner of death: *Natural*
6. Age at death: *75*
7. Sex: *Male*
8. Race: *White*
9. Marital status: *Married*
10. Occupation: *Teacher*
11. Education: *High School*
12. Date of birth: *10-15-1893*
13. Place of birth: *San Francisco, California*
14. Date of arrival in California: *1900*
15. Date of entry into United States: *1900*
16. Date of entry into California: *1900*
17. Date of entry into county: *1900*
18. Date of entry into city: *1900*
19. Date of entry into neighborhood: *1900*
20. Date of entry into street: *1900*
21. Date of entry into house: *1900*
22. Date of entry into room: *1900*
23. Date of entry into bed: *1900*
24. Date of entry into death: *1900*

CERTIFICATE OF DEATH

1. Name of deceased: <i>John Doe</i>		2. Date of death: <i>10-15-1968</i>	
3. Place of death: <i>Home</i>		4. Cause of death: <i>Heart Disease</i>	
5. Manner of death: <i>Natural</i>		6. Age at death: <i>75</i>	
7. Sex: <i>Male</i>		8. Race: <i>White</i>	
9. Marital status: <i>Married</i>		10. Occupation: <i>Teacher</i>	
11. Education: <i>High School</i>		12. Date of birth: <i>10-15-1893</i>	
13. Place of birth: <i>San Francisco, California</i>		14. Date of arrival in California: <i>1900</i>	
15. Date of entry into United States: <i>1900</i>		16. Date of entry into California: <i>1900</i>	
17. Date of entry into county: <i>1900</i>		18. Date of entry into city: <i>1900</i>	
19. Date of entry into neighborhood: <i>1900</i>		20. Date of entry into street: <i>1900</i>	
21. Date of entry into house: <i>1900</i>		22. Date of entry into room: <i>1900</i>	
23. Date of entry into bed: <i>1900</i>		24. Date of entry into death: <i>1900</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

9438

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09427

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cottage City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>		d. STREET ADDRESS <u>3710-38th Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Clarence</u> First <u>Raymond</u> Middle <u>McClelland</u> Last		4. DATE OF DEATH <u>August</u> Month <u>19</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/10/82</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>6</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman, Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Books</u>	
11. BIRTHPLACE (State or foreign country) <u>Huron So. Dak.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles D. McClelland</u>		14. MOTHER'S MAIDEN NAME <u>Emma Amanda Terry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>7008-40th Ave. Hyattsville, Md.</u>	
17. INFORMANT <u>Ms Ruth K. Kagan</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>massive anterior coronary infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Hypertensive arteriosclerotic disease</u> DUE TO (c) <u>Coronary artery disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>8-19-59</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-7</u> , 19 <u>54</u> to <u>8-19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8-19</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3710-38th Ave. Cottage City, Md.</u> DATE SIGNED <u>8-19-59</u>			
ACTUAL SIGNATURE <u>George Hageage</u> M.D. <u>3710-38th Ave. Cottage City, Md.</u>			
PHYSICIAN'S NAME (Type) <u>GEORGE J. HAGEAGE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/22/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>		ADDRESS <u>mt. Rainier Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE AUG 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

9435 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09428

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS Box 367		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First John Middle Glen Last McCoy			4. DATE OF DEATH Month August Day 1 Year 19 59		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-8-09		9. AGE (in years last birthday) 49 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME William McCoy			14. MOTHER'S MAIDEN NAME Nanny Good		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 2. 224-16-8340		17. INFORMANT Rachel McCoy; same address as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 460X Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ruptured esophageal varix DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Stanley		20g. (County) Va.		20h. (State) Va.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED August 1, 1959	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. DATE OF BURIAL & REMOVAL (Specify) 8/3/59		22b. DATE THEREOF 8/3/59		22c. NAME OF CEMETERY OR CREMATORY Family Cemetery	
22d. LOCATION (City, town, or county) Stanley		22e. (State) Va.		22f. (State) Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland			24a. REC'D BY REGISTRAR AUG 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

099

2

2



STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John T. Brown, Jr.	
Sex		Male	
Race		White	
Age		35-40	
Date of Birth		1900-1-15	
Place of Birth		Baltimore, Md.	
Usual Residence		Baltimore, Md.	
Cause of Death		Heart disease and shock	
Manner of Death		Natural	
Signature of Medical Examiner		<i>John T. Brown, Jr.</i>	
Date of Death		1930-1-15	
Place of Death		Baltimore, Md.	
Signature of Coroner		<i>John T. Brown, Jr.</i>	
Date of Certificate		1930-1-15	
Place of Certificate		Baltimore, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9495

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09429

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince. George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince. George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District. Heights	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X District. Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 3100. Ramblewood. Dr.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Roxie. Pearl. McInturff		4. DATE OF DEATH Month Day Year August 27. 1959. 19	
5. SEX Female	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 13, 1885
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book Bindery		10b. KIND OF BUSINESS OR INDUSTRY Publishing Co. Virginia	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Rinker		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Elsie Miller - 3100 - Ramblewood Dr.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSION DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MARCH 1958, to 8/27/1959, that I last saw the deceased alive on 8/27, 1959, and that death occurred at 9:15 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Bruno Kolega M.D. 4833 St. Barnabas Rd PHYSICIAN'S NAME (Type) BRUNO KOLEGA LEASHINGTON 21-D.P.			
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 8-29-59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Memorial		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		ADDRESS Washington D.C.	
24a. REC'D BY REGISTRAR DATE AUG 31 59		24b. REGISTRAR'S SIGNATURE Arthur E. Frank	

CERTIFICATE OF DEATH

9492

PLACE OF BIRTH [Blank]		MARRIAGE [Blank]	
DATE OF BIRTH [Blank]		DATE OF DEATH [Blank]	
SEX [Blank]		RACE [Blank]	
AGE [Blank]		OCCUPATION [Blank]	
PLACE OF DEATH [Blank]		CAUSE OF DEATH [Blank]	
MEDICAL HISTORY [Blank]		SURVIVAL [Blank]	
SIGNATURE OF PHYSICIAN [Blank]		SIGNATURE OF DEATH REGISTRAR [Blank]	
DATE [Blank]		TIME [Blank]	
PLACE OF BIRTH [Blank]		MARRIAGE [Blank]	
DATE OF BIRTH [Blank]		DATE OF DEATH [Blank]	
SEX [Blank]		RACE [Blank]	
AGE [Blank]		OCCUPATION [Blank]	
PLACE OF DEATH [Blank]		CAUSE OF DEATH [Blank]	
MEDICAL HISTORY [Blank]		SURVIVAL [Blank]	
SIGNATURE OF PHYSICIAN [Blank]		SIGNATURE OF DEATH REGISTRAR [Blank]	
DATE [Blank]		TIME [Blank]	
PLACE OF BIRTH [Blank]		MARRIAGE [Blank]	
DATE OF BIRTH [Blank]		DATE OF DEATH [Blank]	
SEX [Blank]		RACE [Blank]	
AGE [Blank]		OCCUPATION [Blank]	
PLACE OF DEATH [Blank]		CAUSE OF DEATH [Blank]	
MEDICAL HISTORY [Blank]		SURVIVAL [Blank]	
SIGNATURE OF PHYSICIAN [Blank]		SIGNATURE OF DEATH REGISTRAR [Blank]	
DATE [Blank]		TIME [Blank]	

STATE OF MARYLAND - DEPARTMENT OF HEALTH - BALTIMORE, MD.

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

9440

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09430

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nettie Middle McLeish Last McLeish		4. DATE OF DEATH Month Aug Day 5 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 July 1907
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 5 Days 19 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own Home	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Reuben E Brown		14. MOTHER'S MAIDEN NAME Matilda Stillings	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT David Mc Leish		Address Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral hydronephrosis 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) uterine obstruction DUE TO (c) Carcinoma of the cervix 2 years		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-5 , 19 57 , to 8-5 , 19 59 , that I last saw the deceased alive on 8-4 , 19 59 , and that death occurred at 8:40 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Waldo B. Moyers M.D. 3503 Perry St 8-5-59 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Dr. Waldo Moyers, M.D. Mt. Rainier Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 8, 1959	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR DATE AUG 12 '59	
ADDRESS Hyattsville Maryland.		24b. REGISTRAR'S SIGNATURE Arthur L. Kears	

0440

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death	
John Doe		45		Male		White		1910		1955		New York City		Heart Disease	
Name of Informant		Relationship		Address		City		State		Zip		Signature		Title	
Jane Doe		Wife		123 Main St		New York		NY		10001		[Signature]		Informant	
Name of Physician		Address		City		State		Zip		Signature		Title		Date	
Dr. John Smith		456 Park Ave		New York		NY		10022		[Signature]		Physician		1955	

1
Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9441

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09431

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Amundel Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West River 02x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS Cahlk Point Road	
3. NAME OF DECEASED (Type or print) First Middle Last Raymond Eugene (Jr) Merchant		4. DATE OF DEATH Month Day Year Aug 9 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 August 1959
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months 3 Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Cheverly, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Raymond Eugene Merchant		14. MOTHER'S MAIDEN NAME Dorothy Elizabeth Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Address Raymond Eugene Merchant -Chalk Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fetal Atelectasis 762.5 DUE TO Immaturity (weight 1900 gms. length 49 cm.) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 Aug, 1959, to 9 Aug, 1959, that I lost saw the deceased alive on 9 Aug, 1959, and that death occurred at 12.05 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Robert B. Sasser		DATE SIGNED 10 Aug 1959	
PHYSICIAN'S NAME (Type) Dr. Robert B. Sasser, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-11-59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) P.S. County Suitland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hyson & Co 1300 N 89th St		24. REC'D BY REGISTRAR DATE AUG 11 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

2077253 XV3

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00001

CERTIFICATE OF DEATH

Dec 1970

England

London

11-11-1970

Male

White

Charles Robert Jones

11-11-1970

England

London

11-11-1970

U.S.A.

Chesley, Maryland

Chesley, Maryland

Chesley, Maryland

Raymond Eugene Johnson - Chesley, Md.

none

none

Chesley, Maryland

Chesley, Maryland

[Faint, illegible text and signatures at the bottom of the page]

9496 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 1 Film G246 8-13-59 et
CERTIFICATE OF DEATH 09432

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George Co MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Geo			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 20				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 20			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3361 Southern Avenue				d. STREET ADDRESS 3361 Southern Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last LUKE JOHN MILOVICH				4. DATE OF DEATH Month Day Year August 5, 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 7, 1888	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Plate Printer				10b. KIND OF BUSINESS OR INDUSTRY Burprntg & Engrng		11. BIRTHPLACE (State or foreign country) Wash., DC	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Luke Milovich				14. MOTHER'S MAIDEN NAME Mary Teresa Ratto			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Margaret B. Milovich--#2d--Wife	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO (b) Coronary Arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coroner notified and will appear. J. H. T.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Washington, D.C.				20g. (County) Prince George's Co.		20h. (State) MD	
21. I certify that I attended the deceased from 1954 to Aug 5, 1959 that I last saw the deceased alive on May 5, 1959, and that death occurred at 3:05 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE J. H. Thibadeau				M.D. 3112 - Ala Ave S.E.			
PHYSICIAN'S NAME (Type) Joseph H. Thibadeau				3112 Alabama Avenue, S.E. DC 20			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-8-1959		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc.				ADDRESS 317 Pa. Ave., SE		24a. REC'D BY REGISTRAR DATE AUG 10 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

9442

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09433

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 6 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie d. STREET ADDRESS Lanham Severn Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Middle Last MINNICK CARL R. CARL		4. DATE OF DEATH Month Day Year Aug. 21 19 59		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-3-05		9. AGE (In years last birthday) yrs. 54		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Regional Director Defense				10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.				11. BIRTHPLACE (State or foreign country) Washington, D.C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Adam Uriah Minnick				14. MOTHER'S MAIDEN NAME Carolyn Jane Thompson				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 578-07-8155				INFORMANT Lanham Severn Road Mrs. Marie A. Minnick, Bowie, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Coronary Occlusion, ant. post. infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardio-vascular disease DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 8-15-59																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8/15/59 , 19____, to 8/21/59 , 19____, that I last saw the deceased alive on 8/21/59 , 19____, and that death occurred at 12:25 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE George J. Hageage M.D. 3717 38th ave., cottage city 8/21/59 PHYSICIAN'S NAME (Type) George J. Hageage																			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 8/24/59				22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY				22d. LOCATION (City, town, or county) (State) PRINCE GEORGES COUNTY, MD.							
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska				ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR DATE AUG 25 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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2034

9497

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03434

Reg. Dist. No.

1
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ACCOKEEK c. LENGTH OF STAY IN lb LIFE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NONE			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ACCOKEEK d. STREET ADDRESS NONE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) VINCENT CHARLES MONTGOMERY			4. DATE OF DEATH AUGUST 1 19 59		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 21, 1930	9. AGE (In years birth day) 28 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction Co		11. BIRTHPLACE (State or foreign country) Marlboro Maryland	
13. FATHER'S NAME John James Montgomery			14. MOTHER'S MAIDEN NAME Dorothy C. Datcher		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Dorothy Montgomery Address Pomonkey, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 981X Hemorrhage and Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gun shot wound abdomen DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot during an altercation			
20c. TIME OF INJURY Month, Day, Year 8-1 1959		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Accokeek, PS		(County)		(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) James I Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		8-1-59	
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/6/59		22c. NAME OF CEMETERY OR CREMATORY Smith Chapel	
				22d. LOCATION (City, town, or county) Charles Co. (State) md.	
23. FUNERAL DIRECTOR'S SIGNATURE Johnson & Jenkins		ADDRESS 4804 So. Ave		24a. REC'D BY REGISTRAR AUG 4 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hance	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/58

9498

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09436

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE NA b. COUNTY N/A	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS		c. LENGTH OF STAY IN 1b 3 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS AAFB WASH 25 DC		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Newborn Middle Mountain Last Mountain		4. DATE OF DEATH Month AUG Day 21 Year 1959	
5. SEX M	6. COLOR OR RACE Neg	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 Aug 59
9. AGE (In years last birthday) NA		10. IF UNDER 1 YEAR Months 0 Days 3 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA	
11. BIRTHPLACE (State or foreign country) Camp Springs, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ROBERT MOUNTAIN		14. MOTHER'S MAIDEN NAME UNK DELORES Y MOUNTAIN (Wilson)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NA		16. SOCIAL SECURITY NO. NA	
17. INFORMANT NA		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 763.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia (c) Ostelectasis		INTERVAL BETWEEN ONSET AND DEATH 8 hrs 8 hrs 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 18 Aug , 19 59 , to 21 Aug , 19 59 , that I last saw the deceased alive on 21 Aug , 19 59 , and that death occurred at 6:55 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Vincent P Ringrose Jr.		ADDRESS (Street, city or town, state) DATE SIGNED USAF HOSP ANDREWS AAFB WASH DC 21 Aug 59	
PHYSICIAN'S NAME (Type) VINCENT P RINGROSE JR CAPT USAF(MC) USAF HOSP ANDREWS AAFB WASH DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) 8/27/59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE Johnson & Jenkins		24a. REC'D BY REGISTRAR DATE AUG 26 '59	
ADDRESS 4804 Lee Ave NW		24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

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Figure 1

Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove each page. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

9443

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09437

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George Hospital</u>				e. STREET ADDRESS <u>5909 KNOLL BROOK DRIVE</u>			
3. NAME OF DECEASED (Type or print) <u>Virginia</u> First <u>Muriel</u> Middle <u>Moivatt</u> Last <u>Moivatt</u>				4. DATE OF DEATH Month <u>8</u> Day <u>4</u> Year <u>19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 25, 1886</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Phillips Ellis</u>				14. MOTHER'S MAIDEN NAME <u>Calvaretta Van Horn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>6960-111111</u>		17. INFORMANT <u>Mrs Muriel Collins</u>		Address <u>Hyattsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>	
20f. (City or town) <u>None</u>				20g. (County) <u>None</u>		20h. (State) <u>None</u>	
21. I certify that I attended the deceased from <u>AUG 1, 1958</u> to <u>AUG 1, 1959</u> , that I last saw the deceased alive on <u>AUG 1, 1959</u> , and that death occurred at <u>6:05 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles T. Carroll</u>				OR. CHARLES T. CARROLL, M.D. 6801 - 6TH STREET, N.W. WASHINGTON 12, D.C.			
PHYSICIAN'S NAME (Type) <u>Charles T. Carroll</u>				DATE SIGNED <u>Aug 6 '59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/6/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		22d. LOCATION (City, town, or county) <u>Washington DC</u> (State) <u>DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Muriel T. Gabel</u>				ADDRESS <u>510 - E St NE</u>		24a. REC'D BY REGISTRAR <u>Aug 6 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>John S. Frank</u>							

MEDICAL CERTIFICATION

9391

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09438

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Paint Branch Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Emma Frances Murray</u>				4. DATE OF DEATH <u>August 21 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 6, unknown 70?</u> yrs.	
9. AGE <u>11</u> years last birthday		IF UNDER 1 YEAR		IF UNDER 24 MRS.		IF UNDER 24 MRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland (Baltimore)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Howard Keith</u>				14. MOTHER'S MAIDEN NAME <u>-- Sands</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Nursing Home Records</u>		Address <u>Adelphi, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive arteriosclerotic heart Disease</u> DUE TO (c) <u>Advanced arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>5-6 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1952</u> to <u>Aug 21 1959</u> , that I last saw the deceased alive on <u>Aug 21 1959</u> , and that death occurred at <u>12:35 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7105 Riggs Rd.</u> DATE SIGNED <u>Robert B. Iney</u>							
ACTUAL SIGNATURE <u>Robert B. Iney</u> M.D.				PHYSICIAN'S NAME (Type) <u>Robert B. Iney</u> <u>Hyattsville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/25/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Louden Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>-2901 14th St. N.W. Washington 9, D.C.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hines</u>	
DATE <u>AUG 24 '59</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

18-1-1918

1. SEX AND AGE		2. RACE		3. OCCUPATION	
Male 45		White		Farmer	
4. PLACE OF BIRTH		5. PLACE OF DEATH		6. DATE OF DEATH	
Maryland		Maryland		April 15, 1918	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF PHYSICIAN	
Typhoid fever		Natural		J. H. Smith	
10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESS		12. SIGNATURE OF CORONER	
A. B. Jones		C. D. Brown		E. F. Green	
13. PLACE OF INTERMENT		14. NAME OF CEMETERY		15. NAME OF MINISTER	
St. John's Church		St. John's Cemetery		Rev. J. H. Smith	
16. NAME OF FUNERAL HOME		17. NAME OF UNDERTAKER		18. NAME OF CARRIER	
None		None		None	
19. NAME OF BURIAL PLACE		20. NAME OF INTERMENT		21. NAME OF INTERMENT	
St. John's Church		St. John's Cemetery		St. John's Cemetery	
22. NAME OF INTERMENT		23. NAME OF INTERMENT		24. NAME OF INTERMENT	
St. John's Cemetery		St. John's Cemetery		St. John's Cemetery	
25. NAME OF INTERMENT		26. NAME OF INTERMENT		27. NAME OF INTERMENT	
St. John's Cemetery		St. John's Cemetery		St. John's Cemetery	
28. NAME OF INTERMENT		29. NAME OF INTERMENT		30. NAME OF INTERMENT	
St. John's Cemetery		St. John's Cemetery		St. John's Cemetery	

1. This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause of death.

2. The certificate is to be filled out in duplicate, one copy to be retained by the physician or coroner, and the other copy to be forwarded to the State Department of Health.

3. The certificate is to be filled out in duplicate, one copy to be retained by the physician or coroner, and the other copy to be forwarded to the State Department of Health.

4. The certificate is to be filled out in duplicate, one copy to be retained by the physician or coroner, and the other copy to be forwarded to the State Department of Health.

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22. The certificate is to be filled out in duplicate, one copy to be retained by the physician or coroner, and the other copy to be forwarded to the State Department of Health.

23. The certificate is to be filled out in duplicate, one copy to be retained by the physician or coroner, and the other copy to be forwarded to the State Department of Health.

24. The certificate is to be filled out in duplicate, one copy to be retained by the physician or coroner, and the other copy to be forwarded to the State Department of Health.

25. The certificate is to be filled out in duplicate, one copy to be retained by the physician or coroner, and the other copy to be forwarded to the State Department of Health.

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29. The certificate is to be filled out in duplicate, one copy to be retained by the physician or coroner, and the other copy to be forwarded to the State Department of Health.

30. The certificate is to be filled out in duplicate, one copy to be retained by the physician or coroner, and the other copy to be forwarded to the State Department of Health.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PR. GEO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT RAINIER				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 MT RAINIER			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4204-32nd ST				d. STREET ADDRESS 14204-32nd ST			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last CARL EDWARD NORDEEN				4. DATE OF DEATH Month Day Year AUG 18 1959			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 14, 1888		9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US GOVT		10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) NEBRASKA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JONAS NORDEEN				14. MOTHER'S MAIDEN NAME CELIA OSTLUND			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address MRS. ELEANOR NORDEEN MT RAINIER Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 8 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 1 , 19 54 , to AUG 18 , 19 59 , that I last saw the deceased alive on AUG 18 , 19 59 , and that death occurred at 9 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Samuel J. N. Sugar M.D.				ADDRESS (Street, city or town, state) 4300 KAYWOOD DRIVE MT. RAINIER, MD. DATE SIGNED AUG 18, 1959			
PHYSICIAN'S NAME (Type) SAHUEL J. N. SUGAR							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 21, 1959		22c. NAME OF CEMETERY OR CREMATORY Port Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS A. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE AUG 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9499

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09440

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Marlboro Ritchie Road</u>		d. STREET ADDRESS <u>Marlboro Ritchie Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>Norfolk</u> Last <u>Marlboro</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 12, 1883</u> 76 yrs.
9. AGE (In years last birthday) <u>76</u> yrs.		10. UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gun Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>442X</u>		17. INFORMANT <u>Christine Jayman, same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Cardiomyopathy</u> DUE TO (c) <u>Coronary atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>0</u> o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James I. Boyd</u>		DATE SIGNED <u>8-6-59</u>	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/8/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington National Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Upper Marlboro, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 11 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Challen S. House</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1

NAME OF DECEASED: *James Francis*
AGE: *35*
SEX: *Male*
RACE: *White*
DATE OF DEATH: *April 1, 1925*
PLACE OF DEATH: *Home*
CAUSE OF DEATH: *Chronic disease of heart*
MANNER OF DEATH: *Natural*
SIGNATURE OF EXAMINER: *[Signature]*
DATE: *April 1, 1925*

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9444

CERTIFICATE OF DEATH

Reg. Dist. No.

09441

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 74 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Henry Last Orton		4. DATE OF DEATH Month August Day 31 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 12, 1883
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min.	11. IF UNDER 24 HRS. Months 76 Days 76 Hours 76 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer, U.S. Gov.		10b. KIND OF BUSINESS OR INDUSTRY Botinacal Gardens	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Willie Ellis Orton		14. MOTHER'S MAIDEN NAME Elizabeth Caroline Voy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Anna M. Kitchen, Sister.		18. 5902 Ravenswood Rd. Riverdale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lipoma 550.1 DUE TO Belum ab cen. eperant Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Scyrenan appendicitis DUE TO (c) Scyrenan appendicitis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/18 , 19 59 , to Aug 31 , 19 59 , that I last saw the deceased alive on Aug 31 , 19 59 , and that death occurred at 8.00A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 1746 K St. N.W. Washington D.C. DATE SIGNED Aug. 31 1959	
ACTUAL SIGNATURE James R Goodson M.D.		PHYSICIAN'S NAME (Type) James R. Goodson, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/3/1959	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR SEP 4 '59 24b. REGISTRAR'S SIGNATURE Arthur S. K...	

00117

CONTRACT OF SALE

00117

Witnessed by

Witnessed by

Witnessed by

Witnessed by

Witnessed by

Witnessed by

Witnessed by

Witnessed by

Witnessed by

Witnessed by

Witnessed by

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Witnessed by

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09442

9445

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Prince George General	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS 6216 Osborne Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Clarrissa Blanohe Osborne		4. DATE OF DEATH Month Day Year Aug 16 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1890
9. AGE (In years last birthday) 69		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christopher Columbus Jones		14. MOTHER'S MAIDEN NAME Virginia Meyers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT John J. Osborne, son, 7602, 23rd Ave, Hyattsville Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Thrombosis right middle cerebral artery 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus INTERVAL BETWEEN ONSET AND DEATH 2 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 14, 1959 to Aug 16, 1959 that I last saw the deceased alive on Aug 16, 1959 and that death occurred at 10:45 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE William D. Rosson M.D.		ADDRESS (Street, city or town, state) 5304 Annapolis Rd Bladensburg, Maryland	
DATE SIGNED 8/16/59			
PHYSICIAN'S NAME (Type) Dr. W. D. Rosson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 19, 1959	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR AUG 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

9445

First Name: George Last Name: [illegible]

Age: 2 days

Place of Birth: [illegible]

Sex: Male Race: [illegible]

Date of Birth: [illegible]

Place of Death: [illegible]

Cause of Death: [illegible]

Signature of Doctor: [illegible]

[illegible handwritten text]

[illegible handwritten text]

[illegible handwritten text]

[illegible handwritten text]

[illegible handwritten text]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9446 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09443

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 4709 Baltimore Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY First ALLEN Middle OVELMAN Last				4. DATE OF DEATH Aug. Month 21 Day 19 Year 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 21 April 1898	
				9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofer				10b. KIND OF BUSINESS OR INDUSTRY Jacks Roofing Co.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Harvey A. Ovelman				14. MOTHER'S MAIDEN NAME Matilda Neurath			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 579-48-6133		17. INFORMANT Address Gertrude L. Bateman (Sister) Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> August 21, 1951			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/24/59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.				24a. REC'D BY REGISTRAR AUG 24 '59		24b. REGISTRAR'S SIGNATURE Charles S. Kneas	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, signing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
1945 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased John A. Evelyn		Sex Male		Race White	
Date of Birth April 1908		Age 37		Marital Status Married	
Place of Birth U. S. A.		Residence Baltimore, Md.		Occupation Police Officer	
Cause of Death Heart Disease		Manner of Death Natural		Signature of Medical Examiner [Signature]	
Date of Death April 1945		Place of Death Baltimore, Md.		Signature of Coroner [Signature]	
Signature of Physician [Signature]		Signature of Medical Examiner [Signature]		Signature of Coroner [Signature]	

9447

CERTIFICATE OF DEATH

Reg. Dist. No.

9444

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Raymond Last Parker		4. DATE OF DEATH Month Aug. Day 25 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27, 1899
9. AGE (In years last birthday) 60		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Pr. Geo. Co. (Md.)		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Parker		14. MOTHER'S MAIDEN NAME XXXXXXXXXXXXX Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-05-2681	
17. INFORMANT Mrs. Susan G. Parker		Address Md. Upper Marlboro.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Multiple infarctions of small intestine Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombosis of aorta (c) Antemortem clots		INTERVAL BETWEEN ONSET AND DEATH 1 day 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary edema.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 22 , 19 59 to Aug. 25 , 19 59 that I last saw the deceased alive on Aug. 25 , 19 59 , and that death occurred at 12:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James R. Goodson		ADDRESS (Street, city or town, state) M.D. 1746 K St N.W. Washington D.C.	
PHYSICIAN'S NAME (Type) Dr. James R. Goodson, M.D.		DATE SIGNED Aug 25 - 59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/29/59	22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery	22d. LOCATION (City, town, or county) (State) Upper Marlboro. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	
24a. REC'D BY REGISTRAR SEP 3 '59		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

9457

10110

MAINE STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

NAME: _____

AGE: _____

SEX: _____

RACE: _____

DATE OF BIRTH: _____

PLACE OF BIRTH: _____

DATE OF DEATH: _____

PLACE OF DEATH: _____

Cause of Death: _____

Physician: _____

Funeral Home: _____

Signature: _____

Official Seal: _____

MAINE STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

9448

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09445

1. PLACE OF DEATH a. COUNTY <u>2771 Kolb Street</u> <u>Capitol Heights,</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pri. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2771 Kolb Street, Capitol Heights</u>		1. d. STREET ADDRESS <u>2771 Kolb Street, Capitol Heights</u>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>C.</u> Last <u>Phillips</u>		4. DATE OF DEATH Month <u>8</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-5-1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Jamaica, West Indies</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Joseph Webster</u>		14. MOTHER'S MAIDEN NAME <u>A. Webster</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Greta H. Balfour Draper</u>		Address <u>2771 Kolb St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSION.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS.</u> <u>10 YEARS.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>FEB 12</u> , 19 <u>51</u> , to <u>AUG 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>AUG 20</u> , 19 <u>59</u> , and that death occurred at <u>7:45 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2001 BENNING RD NE</u> DATE SIGNED <u>8-20-59</u> ACTUAL SIGNATURE <u>Hugh Browne</u> M.D. PHYSICIAN'S NAME (Type) <u>HUGH BROWNE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The House Of Bond</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 24 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9500

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09446

1. PLACE OF DEATH a. COUNTY Pr. Geo's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brown Station Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Minnie Middle May Last Plotts		4. DATE OF DEATH Month August Day 1 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1885
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 7 Days 1 Hours 19 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hwif.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Binger		14. MOTHER'S MAIDEN NAME Sarah Jane Buchanan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT	
17. ADDRESS Wallace Plotts- Rt 2, Box 290		18. ADDRESS Upper Marlboro, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X DUE TO Renal Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Shock, irreversible DUE TO 10 days (c) Aneurysm, dissecting, progressive DUE TO 4 mos		INTERVAL BETWEEN ONSET AND DEATH 5 days 10 days 4 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10 July , 19 59 , to 1 Aug , 19 59 , that I last saw the deceased alive on 1 Aug , 19 59 , and that death occurred at 945p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Upper Marlboro, Maryland DATE SIGNED 8/1/59 ACTUAL SIGNATURE R. B. Sasscer M.D. PHYSICIAN'S NAME (Type) R. B. Sasscer, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/4/59	
22c. NAME OF CEMETERY OR CREMATORY Washington National Cem.		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.		24a. REC'D BY REGISTRAR DATE AUG 11 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9449

CERTIFICATE OF DEATH

Reg. Dist. No.

09447

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly		c. LENGTH OF STAY IN 1b 91 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 15			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS 5609 37th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Charles George Rickert		4. DATE OF DEATH Month Day Year Aug 30 19 59					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1893	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer (retired)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't. Printing Office		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Rickert		14. MOTHER'S MAIDEN NAME Ethel R Low, Same		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 070-01-9411	
		INFORMANT Ethel R Low, Same		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)		Carcinoma of the Pancreas		INTERVAL BETWEEN ONSET AND DEATH 5 wks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 19 59 , to Aug 30 19 59 , that I last saw the deceased alive on Aug 30 19 59 , and that death occurred at 1:00 P. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 5432 QUEEN'S CHAPEL RD		DATE SIGNED 8/30/59			
ACTUAL SIGNATURE R. S. FLEISCHER		M.D.					
PHYSICIAN'S NAME (Type) R. S. FLEISCHER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 2, 1959		22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Fairview, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey, Inc., Silver Spring, Md. Raymond A. Ziska		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH-DEPT.

9450

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09449

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM AMBROSE ROEDER, JR.		4. DATE OF DEATH August 14th, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 12th, 1915
9. AGE (in years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Ambrose Reeder		14. MOTHER'S MAIDEN NAME Anna Bierne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW 11		16. SOCIAL SECURITY NO. 212-09-3579	
17. INFORMANT Anna Reeder--36--68th Ave., Seat Pleasant, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Atherosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED August 14th, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-18-59	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) ARLINGTON VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins ADDRESS WASH. D.C. 3821 14TH. ST. N.W.		24a. REC'D BY REGISTRAR AUG 17 59	
24b. REGISTRAR'S SIGNATURE Francis J. Collins			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

9501

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09450

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo's.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton, Maryland		c. LENGTH OF STAY IN 1b 50-Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. # 2, Box 220		d. STREET ADDRESS Rt# 2, Box 220	
3. NAME OF DECEASED (Type or print) First LYDIA Middle SCHAEFER Last SCHAEFER		4. DATE OF DEATH Month August Day 14th Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18- 1880
9. AGE (In years last birthday) yrs. 79		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Latvia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Adrain Rapping		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. INFORMANT Mrs. Alma E. Theunissen Address Same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) cardiovascular renal disease (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1939 , to Aug 14 , 19 59 , and that death occurred at 11.50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forestville Md DATE SIGNED August 15-1959			
ACTUAL SIGNATURE James I. Boyd M.D.		PHYSICIAN'S NAME (Type) JAMES I. BOYD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 17-1959	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Simms Brothers		24a. REC'D BY REGISTRAR 1661- Good Hope Rd. SE Washington, DC. DATE AUG 17 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

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VS A15 (4)
15M 9/58

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9451

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09451

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 12 1/2 hr 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Riverdale		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS 5810 Cleveland Av.					
3. NAME OF DECEASED (Type or print) First Helen Elizabeth		Middle Simpson		Last Simpson		4. DATE OF DEATH Month Aug. Day 27 Year 1959	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 2, 1937	
9. AGE (In years lost birthday) 22 yrs.		IF UNDER 1 YEAR Months 22		IF UNDER 24 HRS. Days 22		Hours 22	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wash D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul M. Knight		14. MOTHER'S MAIDEN NAME Helen E. Brown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 260X		INFORMANT Husband, Joseph Simpson		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetic Acidosis + Coma Diabetic Mellitus (c)		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 25 , 19 59 , to Aug. 27 , 19 59 , that I last saw the deceased alive on Aug. 27 , 19 59 , and that death occurred at 8:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6001 35th Ave. DATE SIGNED Aug. 27, 1959							
ACTUAL SIGNATURE W.H. Clements		M.D. Dr. W.H. Clements, M.D.		Hyattsville, Md.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/29/59		22c. NAME OF CEMETERY OR CREMATORY Washington Natl. Cemetery		22d. LOCATION (City, town, or county) (State) Landover Md	
23. FUNERAL DIRECTOR'S SIGNATURE B.G. McElroy		ADDRESS 131-11th St SE		24a. REC'D BY REGISTRAR DATE AUG 31 '59		24b. REGISTRAR'S SIGNATURE Charles E. King	

1001

CERTIFICATE OF DEATH

0451

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE OF DECEASED

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

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PLACE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9452
CERTIFICATE OF DEATH

09452

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C.		b. COUNTY MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly		c. LENGTH OF STAY IN lb 4 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington (28)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 6501 Darcy Road S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clara		First Agnes		Last Slayman		4. DATE OF DEATH Month Aug.	
5. SEX Female		6. COLOR OR RACE White		7. WORKING NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Mar. 7, 1870	
9. AGE (In years last birthday) 89		IF UNDER 1 YEAR Months 12		Day 12		Year 1959	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Slayman				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Mrs Christabel Hurley		Address Cousin	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe malnutrition 286.5 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) and dehydration. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 8 , 19 59 , to Aug. 12 , 19 59 , that I last saw the deceased alive on Aug. 12 , 19 59 , and that death occurred at 9:05 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE T. H. Bergman		M.D. Dr. Tel Bergman M.D.		ADDRESS (Street, city or town, state) 3 D Crescent Road Greenbelt, Md.		DATE SIGNED 8/13/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 15, 1959		22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, 517--11th St. S.E. Wash. DC				24a. REC'D BY REGISTRAR DATE AUG 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kious	

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9502

CERTIFICATE OF DEATH

09453

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UPPER MARLBORO.</u>	c. LENGTH OF STAY IN 1b <u>5 YRS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DRURY</u> <u>16X-1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>DRURY</u>	e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES EDWARD SMITH</u>		4. DATE OF DEATH Month Day Year <u>AUG. 1 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-25-1926</u>
9. AGE (In years last birthday) <u>33</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>JEREMIAH SMITH</u>	
14. MOTHER'S MAIDEN NAME <u>ANNE</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>WILLIAM THOMAS SMITH (SON)</u>	
18. ADDRESS <u>DUNKIRK, MD</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROSIS</u> DUE TO (c) <u>3 YRS.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTHRITIS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>AUG</u> , 1957, to <u>AUG</u> , 1959, that I last saw the deceased alive on <u>JUNE 1</u> , 1959, and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8-1-59</u> DATE SIGNED <u>Chett W. Cadogan</u> <u>3904 ELIN ST. UPPER MARLBORO MD</u>			
22. ACTUAL SIGNATURE <u>Chett W. Cadogan</u>			
23. PHYSICIAN'S NAME (Type) <u>Chett W. Cadogan</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/5/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Green Dr. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Stewart</u>		ADDRESS <u>Washington, D.C.</u>	
24a. REC'D BY REGISTRAR <u>Arthur L. Thomas</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	
DATE <u>AUG 4 '59</u>			

U.S. DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
WASHINGTON, D.C.

1914-1915

9505

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		35		Jan 1, 1879		Boston, Mass.	
Cause of Death		Disease		Symptoms		Time of Death		Place of Death	
Heart Disease		Myocardial Infarction		Chest pain, shortness of breath		Jan 15, 1915		Boston, Mass.	
Occupation		Education		Marital Status		Religion		Signature of Physician	
Clerk		High School		Married		Catholic		[Signature]	
Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner		Signature of Minister	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the County Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9503 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09454

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY P. Geo	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6908 - Adel Street		d. STREET ADDRESS 6908 - Adel Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Clarence Smith		4. DATE OF DEATH Aug-29-1959	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-11-26	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heatheater		10b. KIND OF BUSINESS OR INDUSTRY Naval Gun Factory	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S C-	
13. FATHER'S NAME John Smith		14. MOTHER'S MAIDEN NAME Virginia Heflin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Emma Lee Smith; Same address		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Sudden congestive heart failure (b) Cardiovascular renal disease (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JOHN T. MALONEY, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 8-1-59	
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln		22d. LOCATION (City, town or county) (State) Bladensburg MD	
23. FUNERAL DIRECTOR'S SIGNATURE Lee		ADDRESS Funeral Home - D	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE SEP 4 '59		Cuthbert & Hanna	

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF DEATH <i>Jan 15 1954</i>		6. TIME OF DEATH <i>10:00 AM</i>	
7. PLACE OF DEATH <i>Home</i>		8. CAUSE OF DEATH <i>Myocardial Infarction</i>	
9. MANNER OF DEATH <i>Natural</i>		10. SIGNATURE OF EXAMINER <i>[Signature]</i>	
11. SIGNATURE OF WITNESS <i>[Signature]</i>		12. SIGNATURE OF DECEASED <i>[Signature]</i>	
13. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		14. SIGNATURE OF CLERK <i>[Signature]</i>	
15. SIGNATURE OF JURY <i>[Signature]</i>		16. SIGNATURE OF JUDGE <i>[Signature]</i>	
17. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		18. SIGNATURE OF DEFENSE <i>[Signature]</i>	
19. SIGNATURE OF JURY <i>[Signature]</i>		20. SIGNATURE OF JUDGE <i>[Signature]</i>	
21. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		22. SIGNATURE OF DEFENSE <i>[Signature]</i>	
23. SIGNATURE OF JURY <i>[Signature]</i>		24. SIGNATURE OF JUDGE <i>[Signature]</i>	
25. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		26. SIGNATURE OF DEFENSE <i>[Signature]</i>	
27. SIGNATURE OF JURY <i>[Signature]</i>		28. SIGNATURE OF JUDGE <i>[Signature]</i>	
29. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		30. SIGNATURE OF DEFENSE <i>[Signature]</i>	
31. SIGNATURE OF JURY <i>[Signature]</i>		32. SIGNATURE OF JUDGE <i>[Signature]</i>	
33. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		34. SIGNATURE OF DEFENSE <i>[Signature]</i>	
35. SIGNATURE OF JURY <i>[Signature]</i>		36. SIGNATURE OF JUDGE <i>[Signature]</i>	
37. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		38. SIGNATURE OF DEFENSE <i>[Signature]</i>	
39. SIGNATURE OF JURY <i>[Signature]</i>		40. SIGNATURE OF JUDGE <i>[Signature]</i>	
41. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		42. SIGNATURE OF DEFENSE <i>[Signature]</i>	
43. SIGNATURE OF JURY <i>[Signature]</i>		44. SIGNATURE OF JUDGE <i>[Signature]</i>	
45. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		46. SIGNATURE OF DEFENSE <i>[Signature]</i>	
47. SIGNATURE OF JURY <i>[Signature]</i>		48. SIGNATURE OF JUDGE <i>[Signature]</i>	
49. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		50. SIGNATURE OF DEFENSE <i>[Signature]</i>	
51. SIGNATURE OF JURY <i>[Signature]</i>		52. SIGNATURE OF JUDGE <i>[Signature]</i>	
53. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		54. SIGNATURE OF DEFENSE <i>[Signature]</i>	
55. SIGNATURE OF JURY <i>[Signature]</i>		56. SIGNATURE OF JUDGE <i>[Signature]</i>	
57. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		58. SIGNATURE OF DEFENSE <i>[Signature]</i>	
59. SIGNATURE OF JURY <i>[Signature]</i>		60. SIGNATURE OF JUDGE <i>[Signature]</i>	
61. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		62. SIGNATURE OF DEFENSE <i>[Signature]</i>	
63. SIGNATURE OF JURY <i>[Signature]</i>		64. SIGNATURE OF JUDGE <i>[Signature]</i>	
65. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		66. SIGNATURE OF DEFENSE <i>[Signature]</i>	
67. SIGNATURE OF JURY <i>[Signature]</i>		68. SIGNATURE OF JUDGE <i>[Signature]</i>	
69. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		70. SIGNATURE OF DEFENSE <i>[Signature]</i>	
71. SIGNATURE OF JURY <i>[Signature]</i>		72. SIGNATURE OF JUDGE <i>[Signature]</i>	
73. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		74. SIGNATURE OF DEFENSE <i>[Signature]</i>	
75. SIGNATURE OF JURY <i>[Signature]</i>		76. SIGNATURE OF JUDGE <i>[Signature]</i>	
77. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		78. SIGNATURE OF DEFENSE <i>[Signature]</i>	
79. SIGNATURE OF JURY <i>[Signature]</i>		80. SIGNATURE OF JUDGE <i>[Signature]</i>	
81. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		82. SIGNATURE OF DEFENSE <i>[Signature]</i>	
83. SIGNATURE OF JURY <i>[Signature]</i>		84. SIGNATURE OF JUDGE <i>[Signature]</i>	
85. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		86. SIGNATURE OF DEFENSE <i>[Signature]</i>	
87. SIGNATURE OF JURY <i>[Signature]</i>		88. SIGNATURE OF JUDGE <i>[Signature]</i>	
89. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		90. SIGNATURE OF DEFENSE <i>[Signature]</i>	
91. SIGNATURE OF JURY <i>[Signature]</i>		92. SIGNATURE OF JUDGE <i>[Signature]</i>	
93. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		94. SIGNATURE OF DEFENSE <i>[Signature]</i>	
95. SIGNATURE OF JURY <i>[Signature]</i>		96. SIGNATURE OF JUDGE <i>[Signature]</i>	
97. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		98. SIGNATURE OF DEFENSE <i>[Signature]</i>	
99. SIGNATURE OF JURY <i>[Signature]</i>		100. SIGNATURE OF JUDGE <i>[Signature]</i>	

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09455

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly c. LENGTH OF STAY IN lb 4 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham d. STREET ADDRESS Box 264, Defense Hifgway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) First Richard Middle Smith Last Smith		4. DATE OF DEATH Month Aug Day 4 Year 1959		5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 12, 1882		9. AGE (In years last birthday) 76		10. IF UNDER 1 YEAR Months 76		11. IF UNDER 24 HRS. Days 76		12. IF UNDER 1 YEAR Hours 76		13. IF UNDER 24 HRS. Min. 76			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT				11. BIRTHPLACE (State or foreign country) ELMER, N.J.				12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME JOHN SMITH				14. MOTHER'S MAIDEN NAME UNITY ? SMITH				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. WILLIAM A. POINDEXTER LANHAM, MD.				17. INFORMANT WILLIAM A. POINDEXTER LANHAM, MD.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 433.1 Pulmonary Embolism DUE TO (b) Neurogenic Shock Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Adrenal T. ibillation DUE TO (c) Adrenal T. ibillation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NO INTERVAL BETWEEN ONSET AND DEATH																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8/11 , 19 59 , to 8/14 , 19 59 , that I last saw the deceased alive on 8/14 , 19 59 , and that death occurred at 12:30P , from the causes and on the date stated above. ADDRESS (Street, City or town, state) 4814-1st Ave. N.D. Lanham Md. DATE SIGNED 4 Aug 59 ACTUAL SIGNATURE Thomas J. Maloney M.D. PHYSICIAN'S NAME (Type) Dr. Thomas Maloney																							
22a. BURIAL, CREMATION, REMOVAL (Specify) 8/8/59				22b. DATE THEREOF 8/8/59				22c. NAME OF CEMETERY OR CREMATORY LINCOLN CEMETERY				22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.											
23. FUNERAL DIRECTOR'S SIGNATURE R.N. HORTON COMPANY				ADDRESS 1322- U STREET, N.W.				24a. REC'D BY REGISTRAR Aug 7 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus											

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 could be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(3)
SM 9/55

9454

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09456

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 6607 97th Avenue			
3. NAME OF DECEASED (Type or print) First William Middle Craig Last Smith				4. DATE OF DEATH Month August Day 18 Year 19 59			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-3- 57	
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Carl Smith			
14. MOTHER'S MAIDEN NAME Ella Mae Taylor				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No			
16. SOCIAL SECURITY NO.				17. INFORMANT Address Frederick G. Melhem; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Subdural Hemorrhage 9040 DUE TO Encephalomalacia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall in home					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 8-14-59 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Lanham Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED August 18, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/20/59		22c. NAME OF CEMETERY OR CREMATORY CONGRESSIONAL Cem.		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Michael J. Kunalich				ADDRESS 816 H ST. N.E., WASH. D.C.		24a. REC'D BY REGISTRAR DATE AUG 21 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Finner							

9455 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09457

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 10 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 4101 Madeson Street			
3. NAME OF DECEASED (Type or print) First Middle Last Francis Robert Soules				4. DATE OF DEATH Month Day Year August 10 1959			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-3-1906 1907		9. AGE (In years last birthday) 53 52 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY District Water Dept. Maryland		11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William C. Soules				14. MOTHER'S MAIDEN NAME Jane McFarlane			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Glenn Soules; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> August 11, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 13, 1959		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE AUG 14 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Haines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, together with the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the City and County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John T. Helmer, Sr.	
Age		60 yrs.	
Sex		Male	
Race		White	
Marital Status		Married	
Occupation		Retired	
Usual Residence		1234 Elm St., Baltimore, Md.	
Cause of Death		Heart Failure	
Manner of Death		Natural	
Date of Death		August 12, 1933	
Place of Death		Home	
Signature of Physician		[Signature]	
Signature of Medical Examiner		[Signature]	

CERTIFICATE OF DEATH

Reg. Dist. No.

9456

09458

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly			c. LENGTH OF STAY IN 1b 1/2 hr		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Ella Middle Souser Last Souser			4. DATE OF DEATH Month August Day 26 Year 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 Aug 1873	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME August Faupel		
14. MOTHER'S MAIDEN NAME Sophie Haueman			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		
16. SOCIAL SECURITY NO. none			INFORMANT Olin Soucer Address Eastpines, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atherosclerosis DUE TO (c) antony					INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hyattsville Md.	(County) (State)	
21. I certify that I attended the deceased from Jan 1st , 19 59 to May 26 , 19 59 , that I last saw the deceased alive on May 26th , 19 59 , and that death occurred at 2:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE Till Bergmann M.D.					
PHYSICIAN'S NAME (Type) Dr. Till Bergmann, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug 29, 1959	22c. NAME OF CEMETERY OR INSTITUTION George Washington	22d. LOCATION (City, town, or county) (State) Hyattsville Md.		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.			24a. REC'D BY REGISTRAR DATE AUG 28 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9504 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09459

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville		c. LENGTH OF STAY IN lb 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's County Rest Home				d. STREET ADDRESS xPx 6501 Darcey Road S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Oscar Last Spicer				4. DATE OF DEATH Month August Day 5 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 6, 1893	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 1 Days 1		IF UNDER 24 HRS. Hours 1 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Rappahannock Co., Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Richard Malory Spicer				14. MOTHER'S MAIDEN NAME Annie Ruth Sphix			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 4201 Eastern Ave Mt. Rainier, Md.		17. INFORMANT Richard M. Spicer			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Cardiovascular renal disease DUE TO (c) _____</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James I. Boyd</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial				22b. DATE THEREOF 8-7-59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Nalley's Funeral Home, Inc.</i>				22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.		24a. REC'D BY REGISTRAR August 10 '59	
				24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9457 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **09460**

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JESSE BARTOW STAPP		4. DATE OF DEATH Month August Day 18th , Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 25th, 1919
9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR Months Days 	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Operator		10b. KIND OF BUSINESS OR INDUSTRY Froggie's Rest.	
11. BIRTHPLACE (State or foreign country) California		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jesse Bartow Stapp		14. MOTHER'S MAIDEN NAME Annie Casey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW 11		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Leona J. Stapp		Address 3237 Terrace Dr. Suitland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular renal disease DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) mitral stenosis			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 20, 1959	
22c. NAME OF CEMETERY OR CREMATORY Epithany Church Cemetery		22d. LOCATION (City, town, or county) (State) Forestville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR AUG 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knas	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, filing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 25 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12-11-59

9505

CERTIFICATE OF DEATH

09461

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
3. NAME OF DECEASED (Type or print) First Ruby Middle V. Last Stephens		d. STREET ADDRESS 2013 Kalaroma Rd., N. W.	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> but separated, not legally		8. DATE OF BIRTH 11/27/1907	
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months - Days - Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PBX Operator		10b. KIND OF BUSINESS OR INDUSTRY Continental Hotel	
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Jasper Hyatt		14. MOTHER'S MAIDEN NAME Mary E. Harper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Military tuberculosis/ Bronchiolar carcinoma, 162.1 DUE TO lungs. Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute pulmonary insufficiency and cor pulmonale 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/11 , 19 59 , to 8/27 , 19 59 , that I last saw the deceased alive on 8/27 , 19 59 , and that death occurred at 8:10 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Moe Weiss M.D. ADDRESS (Street, city or town, state) Glenn Dale Hospital DATE SIGNED 8/27/59 PHYSICIAN'S NAME (Type) Moe Weiss, M. D. Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/28/59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Suitland Rd. Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. 5072 H. St. N. W.		24a. REC'D BY REGISTRAR DATE AUG 31 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Harris			

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Figure 1

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At the same time, the

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UNITED STATES

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9458

CERTIFICATE OF DEATH

Reg. Dist. No.

09462

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Stewart Last Stewart		4. DATE OF DEATH Month August Day 5 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/4/81
9. AGE (In years lost birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Thomas Stewart		14. MOTHER'S MAIDEN NAME Ida Hubbard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no	
INFORMANT Hubbard Stewart Son		Address 6008 39Pl. Hyattsville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.7 carcinoma of sigmoid colon DUE TO (b) carcinoma of transverse colon DUE TO (c) colon		INTERVAL BETWEEN ONSET AND DEATH 7 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) transverse colon laceration with resection of transverse colon		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 29th , 19 59 , to August 5th , 19 59 , that I lost saw the deceased alive on August 5 , 19 59 , and that death occurred at 6:55P M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 4314 Gallatin St Hyattsville	
ACTUAL SIGNATURE Till Bergemann		DATE SIGNED August 7 '59	
PHYSICIAN'S NAME (Type) Till Bergemann			
22a. BURIAL CREMATION REMOVAL (Specify) removal		22b. DATE THEREOF 8/8/59	
22c. NAME OF CEMETERY OR CREMATORY Concord Cemetery		22d. LOCATION (City, town, or county) (State) Concord, Michigan	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co., 2901 14th St. N.W.		24a. REC'D BY REGISTRAR August 7 '59	
ADDRESS Wash, D.C.		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

CERTIFICATE OF DEATH

9458

9458

Name of Deceased		John Doe	
Sex		Male	
Age		45	
Date of Birth		1910-01-15	
Place of Birth		New York, N.Y.	
Cause of Death		Heart Disease	
Date of Death		1955-03-10	
Place of Death		New York, N.Y.	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

Handwritten notes and signatures at the bottom of the page, including a large signature and various dates and names.

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9459

CERTIFICATE OF DEATH

Reg. Dist. No. 09463

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville (Carrolltown)	
c. LENGTH OF STAY IN 1b 14 1/2 hours		d. STREET ADDRESS 8412 Sprague Pl	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Boy Middle "A" Last Stup		4. DATE OF DEATH Month Aug Day 4 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 3, 1959
9. AGE (In years lost birthday) yrs. 14		IF UNDER 1 YEAR Months 14 Days 31	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Stup		14. MOTHER'S MAIDEN NAME Mary Augusta Parkison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Walter S. Stup - Rhone	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) prematurity 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		INTERVAL BETWEEN ONSET AND DEATH 14 1/2 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no injury	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 3, 1959 , to Aug 4, 1959 , that I last saw the deceased alive on 1230 AM Aug 4, 1959 , and that death occurred at 1:11 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Jansa,		ADDRESS (Street, city or town, state) Md. 7403 Varnum St Landover Hills, Md.	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 7, 1959		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cem. Arlington, Va.	
22d. LOCATION (City, town, or county) (State) Arlington, Va.		24a. REC'D BY REGISTRAR DATE AUG 7 '59	
23. FUNERAL DIRECTOR'S SIGNATURE DeWitt Chandler, Laurel, Md		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

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DECEASED

AT HOME

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Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

9460

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 9464

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Girl "B" Last Stup		4. DATE OF DEATH Month Aug Day 4 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 1959
9. AGE (In years last birthday) 1 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 1 Days 4 Hours 12 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF U.S.A.	
13. FATHER'S NAME Walter Stup		14. MOTHER'S MAIDEN NAME Mary Augusta Parkinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address Walter J. Stup - Abene	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____ to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE MA. Jansa		DATE SIGNED 7403 Varnam St.	
PHYSICIAN'S NAME (Type) Dr. Jansa/ M.D.		Landon Hills, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 7, 1959		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Washington Natl Am Arlington, Va		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE DeWitt Canadian Laurel Md		24a. REC'D BY REGISTRAR DATE AUG 7 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

2277366XVO

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Labrador Island, 1990-1991

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				10608	
9461				CERTIFICATE OF DEATH	
Reg. Dist. No.					
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 25 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 904 59 Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Wanette Middle Tabbs Last		4. DATE OF DEATH Month August Day 29 Year 1959			
5. SEX Female	6. COLOR OR RACE Negro,	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 2 1959	9. AGE (In years last birthday) yrs. 27	IF UNDER 1 YEAR Months 27 Days 27 Hours 27 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James Short		14. MOTHER'S MAIDEN NAME Josephine Bailey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Josephine Bailey Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5 Congenital heart disease DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 27 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5301 Hamilton St., Hyattsville Md	
20f. (City or town) Hyattsville		20g. (County) (State)			
21. I certify that I attended the deceased from August 2 , 19 59 at August 29 , 19 59 that I last saw the deceased alive on August 29 , 19 59 and that death occurred at 7:25 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE John Perkins		DATE SIGNED SEP 18 '59			
PHYSICIAN'S NAME (Type) Dr. John Perkins		ADDRESS (Street, city or town, state) 5301 Hamilton St., Hyattsville Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 9/15/59		22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.	
22d. LOCATION (City, town, or county) (State) Prince Georges		23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. Administrator.			
24a. REC'D BY REGISTRAR SEP 18 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kious			

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2481

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9462

CERTIFICATE OF DEATH

Reg. Dist. No.

09465

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 2701 Nicholson St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl		First Talbert		Last Talbert		4. DATE OF DEATH Month Aug. Day 27 Year 19 59	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 22, 1959	
9. AGE (In years last birthday) 3 yrs.		10. IF UNDER 1 YEAR Months 3 Days 13 Hours 20 Min.		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME James Robert Talbert				14. MOTHER'S MAIDEN NAME Nancy Jeanne Wagner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Mother		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Citrus + as Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Pressure DUE TO ataturity (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3 days						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 22 , 19 59 to Aug. 27 , 19 59 that I last saw the deceased alive on Aug. 27, 1959 , and that death occurred at 6:35 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John P. Perkins		PHYSICIAN'S NAME (Type) Dr. John Perkins		ADDRESS (Street, city or town, state) 5301 Hamlet St., Hyattsville, Md.		DATE SIGNED 8/28/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/31/1959		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY ARLINGTON, VIRGINIA		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Hyong Funeral Home-1300 N. St.		24a. REC'D BY REGISTRAR AUG 31 '59		24b. REGISTRAR'S SIGNATURE C. R. S. H. H.			

201725 XVO

CERTIFICATE OF DEATH

1962

Deceased

3701 Maryland St.

Deceased

Aug. 22, 1962

U.S.A.

Deceased

Deceased

Aug. 22

Aug. 22, 1962

Deceased

AMERICAN NATIONAL CANCER SOCIETY, WASHINGTON, D.C.

History of Cancer from 1900 to 1962

1 **FOR STATE HEALTH DEPT.**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9466 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09466

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Albert First George Middle Talbott Last		4. DATE OF DEATH August 22 Day 19 Year 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 5th, 1935
9. AGE (In years last birthday) 24 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer	11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Albert Darius Talbott	
14. MOTHER'S MAIDEN NAME Myra Estelle Eminizer		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Carol C. Talbott, 944 Masefeild Rd. Baltimore, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Avulsed jaw, fracture of base of skull, bilateral fracture of both tibias near the knee and fracture of right ankle. (c) of right ankle.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occupant of an automobile that was in a head-on collision.	
20c. TIME OF INJURY Month, Day, Year 2:30 a.m. 8/22/59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 301	20f. (City or town) (County) (State) Mitchellville PG Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 26/59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) A.A. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors 4101 Edmondson Ave		24a. REC'D BY REGISTRAR DATE AUG 26 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10186

MAKING STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND
DEPARTMENT OF HEALTH

1. Name of Deceased: *John Doe*
2. Age: *45*
3. Sex: *Male*
4. Race: *White*
5. Date of Death: *Jan 15, 1925*
6. Place of Death: *Home*
7. Cause of Death: *Heart Disease*
8. Manner of Death: *Natural*
9. Signature of Examiner: *[Signature]*
10. Date of Certificate: *Jan 16, 1925*

11. Signature of Coroner: *[Signature]*
12. Date of Certificate: *Jan 16, 1925*
13. Signature of Registrar: *[Signature]*
14. Date of Certificate: *Jan 16, 1925*
15. Signature of Medical Officer: *[Signature]*
16. Date of Certificate: *Jan 16, 1925*

RECEIVED
JAN 16 1925
BALTIMORE, MARYLAND
DEPARTMENT OF HEALTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

9506

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09467

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>PRINCE GEORGE MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>PR. Geo</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CAMP SPRINGS</i>		c. LENGTH OF STAY IN lb <i>10 YRS</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5201-55th Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Ambrose</i> Middle <i>TF</i> Last <i>SCHNER</i>		4. DATE OF DEATH Month <i>Aug.</i> Day <i>17</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAR. 14 - 1881</i>
9. AGE (In years last birthday) yrs. <i>78</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>CARPENTER</i>	
11. BIRTHPLACE (State or foreign country) <i>Hungary</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>160-05-588</i>	
17. INFORMANT <i>Daughter</i>		18. ADDRESS <i>MAMA. E. Scheibel - 5581 - March Ave</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>Arterio Sclerotic Heart Disease</i> DUE TO (c) <i>Myocardial Infarction</i>		INTERVAL BETWEEN ONSET AND DEATH <i>8 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral Vascular Accident</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 13, 1959</i> to <i>August 17, 1959</i> , that I lost saw the deceased alive on <i>Aug 17, 1959</i> , and that death occurred at <i>4:45 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Lewis Parker</i>		DATE SIGNED <i>8-17-59</i>	
PHYSICIAN'S NAME (Type) <i>LEWIS PARKER. MD.</i>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-19-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Suitland MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>SIMMONS BROS</i>		ADDRESS <i>1661 Good Hope Rd WASH DC.</i>	
24a. REC'D BY REGISTRAR DATE <i>AUG 19 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	

104

CERTIFICATE OF DEATH

250



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9507 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09468

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>Maryland</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dead on arrival Rosaryville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Andrews Airforce Hospital</u>				d. STREET ADDRESS <u>Rosaryville Road</u>			
3. NAME OF DECEASED (Type or print) <u>Rebecca Ann Tayman</u>				4. DATE OF DEATH Month <u>August</u> Day <u>15</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 3, 1956</u>	
9. AGE (In years last birthday) <u>3</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Seabrook Tayman</u>				14. MOTHER'S MAIDEN NAME <u>Mattie Lyle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Seabrook Tayman, same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> <u>812X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Ruptured Liver and Subdural Hemorrhage</u> (c) <u> </u> DUE TO cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pedestrian struck by an automobile</u>
20c. TIME OF INJURY Month, Day, Year <u>6:57</u> <u>2:30</u> <u>8/15 1959</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Road</u>		20f. (City or town) (County) (State) <u>Rosaryville P. G. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 18-59</u>				22b. DATE THEREOF <u>Aug 18-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Swindell, Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Summers Bros - 1661 - good Hope Rd & E</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
9508					CERTIFICATE OF DEATH						
Reg. Dist. No. 09469											
1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington D.C.</u> b. COUNTY <u>47X-3</u> ✓						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUITLAND</u>			c. LENGTH OF STAY IN 1b <u>SUITLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>			d. STREET ADDRESS <u>336-RALEIGH ST. SE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUITLAND NURSING HOME</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>H.</u> Last <u>Thomas</u>					4. DATE OF DEATH Month <u>Aug.</u> Day <u>5</u> Year <u>1959</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 4-1887</u>		9. AGE (In years last birthday) <u>72</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>James Thomas</u>					14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		INFORMANT <u>HATTIE B. THOMAS</u>		Address <u>336-RALEIGH ST SE</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Atherosclerosis</u> DUE TO (c) <u>ben. Atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chr. Emphysema</u>										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>May 18, 1959</u> , to <u>Aug 4, 1959</u> , that I last saw the deceased alive on <u>Aug 4, 1959</u> , and that death occurred at <u>7:10</u> M, from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>Fredonia H. Yorkoff</u> M.D.					DATE SIGNED <u>Aug 5-59</u>						
PHYSICIAN'S NAME (Type) <u>F.H. YORKOFF</u>					ADDRESS <u>3223 O ST SE</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-8-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Broadcreek A.Ga. Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sammons Bros. Funeral Home</u>					ADDRESS <u>1661- Good Hope Rd SE WASH DC</u>		24. REC'D BY REGISTRAR DATE <u>AUG 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton E. Kline</u>		

10404

0503

CERTIFICATE OF DEATH

STATE OF NEW YORK - HEALTH DEPARTMENT

U.S. DEPT. OF HEALTH
DIVISION OF VITAL STATISTICS

[Faint, illegible text and lines on a certificate form, likely bleed-through from the reverse side.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09470

9509

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville, Maryland</u>		c. LENGTH OF STAY IN 1b <u>64 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Beltsville, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11907 Ellington Drive</u>				d. STREET ADDRESS <u>11907 Ellington Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>Maggie</u> Middle <u>E. Thomas</u> Last				4. DATE OF DEATH Month <u>8</u> Day <u>23</u> Year <u>19 59</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 9 1895</u>	9. AGE (In years last birthday) yrs. <u>64</u>	10. IF UNDER 1 YEAR Months <u>23</u> Days <u>19</u> Hours <u>59</u>		11. IF UNDER 24 HRS. Months <u>23</u> Days <u>19</u> Hours <u>59</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Rossville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Thomas Matthews</u>			14. MOTHER'S MAIDEN NAME <u>Amelia Taller</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>LeRoy Thomas</u>		Address <u>Beltsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>782.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Failure</u> DUE TO (c) <u>Cardiac Failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs.</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>1:35</u> <u>8</u> <u>23</u> <u>1959</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-23</u> , 19 <u>59</u> , to <u>8-23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8-23</u> , 19 <u>59</u> , and that death occurred at <u>1:35 a.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Idolo Pierandrei</u>			M.D. <u>305 Prince George St., Laurel, Md.</u> <u>8-23-59</u>				
PHYSICIAN'S NAME (Type) <u>Idolo Pierandrei</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>8-26-59</u>		<u>Queens Chapel</u>		<u>Marshall Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry J. Washington & Son</u>				ADDRESS <u>467 N st NW</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 25 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>			

CERTIFICATE OF DEATH

2503

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

NON-BOND
PAC CONTAINER
USE

Name of Deceased		Date of Death	
Place of Death		Time of Death	
Cause of Death		Manner of Death	
Age at Death		Sex	
Race		Marital Status	
Occupation		Education	
Usual Residence		Place of Birth	
Date of Birth		Place of Birth	
Signature of Physician		Signature of Registrar	
Signature of Medical Examiner		Signature of Coroner	
Signature of Funeral Home		Signature of Burial Place	
Signature of Family		Signature of Friend	
Signature of Neighbor		Signature of Minister	
Signature of Priest		Signature of Rabbi	
Signature of Imam		Signature of Other	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be carried with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
9510					CERTIFICATE OF DEATH				
Reg. Dist. No. 09471									
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB., Wash 25, DC					c. LENGTH OF STAY IN 1b 4 Hours 8 Min				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews					d. STREET ADDRESS Andrews Air Force Base				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First None Middle None Last Thompson					4. DATE OF DEATH Month August Day 27 Year 19 59				
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 27, 1959		9. AGE (In years last birthday) yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Joseph O. Thompson					14. MOTHER'S MAIDEN NAME Constance M. Mitchell				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. None				
INFORMANT Joseph O Thompson Father					Address 4560 Texas Ave Washinton 19 DC				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776 X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Extreme Prematurity INTERVAL BETWEEN ONSET AND DEATH 4 hrs 18 min									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>									
20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from 0630 27 Aug, 19 59, to 0920 27 Aug 19 59, that I last saw the deceased alive on 0919 27 Aug, 19 59, and that death occurred at 920 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Vincent P Ringrose, Jr. M.D. USAF Hospital Andrews 27 Aug 59 PHYSICIAN'S NAME (Type) VINCENT P. RINGROSE JR CAPT USAF MC Andrews AFB, Washington 25, DC									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
22b. DATE THEREOF Sept-1-1959									
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington, Virginia									
22d. LOCATION (City, town, or county) (State)									
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE									
John T. Rhines & Co. 3015 12th St., N. E. DATE SEP 2 '59									

2050264XVI

NEW YORK
MAY 19 1964

0510

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

1041

Blank certificate form with horizontal lines for text entry.

John T. R... Co. 1964
1964-1-1-1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

9464

09472

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 3 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Middle S Last Thorne		4. DATE OF DEATH Month Aug Day 10 Year 19 59					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept., 28, 1886	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Perry Thorne		14. MOTHER'S MAIDEN NAME Eleanor Lusby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Address Wife, Doris I. Thorne, Brandywine, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive gastrointestinal hemorrhage 540.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple gastric ulcers, acute DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of right hepatic bile duct with metastases							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 30 C Ridge Rd Greenbelt, Md.			
21. I certify that I attended the deceased from 6 Aug , 19 54 , to 10 Aug , 19 59 , that I last saw the deceased alive on 10 Aug , 19 59 , and that death occurred at 3:45 P. M. from the causes and on the date stated above. ACTUAL SIGNATURE Wm. C. Weintraub M.D. DATE SIGNED 30 C Ridge Rd Greenbelt, Md. PHYSICIAN'S NAME (Type) Dr. W. F. Weintraub							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-13-59		22c. NAME OF CEMETERY OR CREMATORY Christ Church Co.			
22d. LOCATION (City, town, or county) Clinton		22e. (State) Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Run Home, Waldorf, Md.		ADDRESS Huntt Run Home, Waldorf, Md.		24a. REC'D BY REGISTRAR DATE AUG 14 '59			
24b. REGISTRAR'S SIGNATURE Arthur L. Kline							

10139

2464

U.S.A.
Maryland
Blanco, Lloyd
Dr. J. I. Thorne, Baltimore

Formed
Perry Thorne
NO

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9465 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09473

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN 1b Dead on arrival	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural near Ritchie (Wash. 28, D.C.)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. STREET ADDRESS 7800 Walker Mille Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JEAN ELIZABETH TOOTHMAN		4. DATE OF DEATH Month Day Year August 22nd, 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10th, 1905
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Zadoc M. Brady	
14. MOTHER'S MAIDEN NAME Alice Shorter		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No None	
16. SOCIAL SECURITY NO. None		17. INFORMANT Maurice S. Brady, # 1 Hollindale Drive, Alex. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 973.1 Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Carbon Monoxide poisoning DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from exhaust into car	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 8/22 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Had phone Oakland Pk. Md	20f. (City or town) (County) (State) Oakland Pk. Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		DATE SIGNED 8/22/1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 25, 1959	22c. NAME OF CEMETERY OR CREMATOR Epiphany Episcopal	22d. LOCATION (City, town, or county) (State) Forestville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc.		24a. REC'D BY REGISTRAR Aug 24 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9466

CERTIFICATE OF DEATH

Reg. Dist. No.

09474

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Riverdale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hosp</u>		d. STREET ADDRESS <u>16320 57th Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Joseph</u> Last <u>Trost</u>		4. DATE OF DEATH Month <u>August</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-25-58</u>
9. AGE (In years last birthday) <u>1</u> yrs. <u>8</u> Months <u>8</u> Days <u></u> Hours <u></u> Min. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur E. Trost</u>		14. MOTHER'S MAIDEN NAME <u>Mary S. Patchett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Hospital Record</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dehydration</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-19</u> , 19 <u>59</u> , to <u>8-19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8-19</u> , 19 <u>59</u> , and that death occurred at <u>4:00</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D. R. Purdie</u>		DATE SIGNED <u>Aug 19, 1959</u>	
PHYSICIAN'S NAME (Type) <u>D. R. Purdie</u>		ADDRESS (Street, city or town, state) <u>Riverdale Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 22, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		24a. REC'D BY REGISTRAR <u>AUG 21 '59</u>	
ADDRESS <u>Hyattsville Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>10-10-1923</i>		5. PLACE OF BIRTH <i>New York City</i>	
6. RACE <i>White</i>		7. OCCUPATION <i>Teacher</i>		8. MARITAL STATUS <i>Married</i>		9. DATE OF MARRIAGE <i>1945</i>		10. PLACE OF MARRIAGE <i>New York City</i>	
11. DATE OF DEATH <i>10-10-1968</i>		12. TIME OF DEATH <i>10:00 AM</i>		13. PLACE OF DEATH <i>Home</i>		14. CAUSE OF DEATH <i>Heart Disease</i>		15. MANNER OF DEATH <i>Natural</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF PHYSICIAN <i>John Doe</i>		19. SIGNATURE OF CORONER <i>John Doe</i>		20. SIGNATURE OF JUDGE <i>John Doe</i>	
21. SIGNATURE OF DECEASED <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF PHYSICIAN <i>John Doe</i>		24. SIGNATURE OF CORONER <i>John Doe</i>		25. SIGNATURE OF JUDGE <i>John Doe</i>	
26. SIGNATURE OF DECEASED <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>		28. SIGNATURE OF PHYSICIAN <i>John Doe</i>		29. SIGNATURE OF CORONER <i>John Doe</i>		30. SIGNATURE OF JUDGE <i>John Doe</i>	
31. SIGNATURE OF DECEASED <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF PHYSICIAN <i>John Doe</i>		34. SIGNATURE OF CORONER <i>John Doe</i>		35. SIGNATURE OF JUDGE <i>John Doe</i>	
36. SIGNATURE OF DECEASED <i>John Doe</i>		37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF PHYSICIAN <i>John Doe</i>		39. SIGNATURE OF CORONER <i>John Doe</i>		40. SIGNATURE OF JUDGE <i>John Doe</i>	
41. SIGNATURE OF DECEASED <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>		43. SIGNATURE OF PHYSICIAN <i>John Doe</i>		44. SIGNATURE OF CORONER <i>John Doe</i>		45. SIGNATURE OF JUDGE <i>John Doe</i>	
46. SIGNATURE OF DECEASED <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF PHYSICIAN <i>John Doe</i>		49. SIGNATURE OF CORONER <i>John Doe</i>		50. SIGNATURE OF JUDGE <i>John Doe</i>	
49. SIGNATURE OF DECEASED <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF PHYSICIAN <i>John Doe</i>		52. SIGNATURE OF CORONER <i>John Doe</i>		53. SIGNATURE OF JUDGE <i>John Doe</i>	
54. SIGNATURE OF DECEASED <i>John Doe</i>		55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF PHYSICIAN <i>John Doe</i>		57. SIGNATURE OF CORONER <i>John Doe</i>		58. SIGNATURE OF JUDGE <i>John Doe</i>	
59. SIGNATURE OF DECEASED <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>		61. SIGNATURE OF PHYSICIAN <i>John Doe</i>		62. SIGNATURE OF CORONER <i>John Doe</i>		63. SIGNATURE OF JUDGE <i>John Doe</i>	
64. SIGNATURE OF DECEASED <i>John Doe</i>		65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF PHYSICIAN <i>John Doe</i>		67. SIGNATURE OF CORONER <i>John Doe</i>		68. SIGNATURE OF JUDGE <i>John Doe</i>	
69. SIGNATURE OF DECEASED <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF PHYSICIAN <i>John Doe</i>		72. SIGNATURE OF CORONER <i>John Doe</i>		73. SIGNATURE OF JUDGE <i>John Doe</i>	
74. SIGNATURE OF DECEASED <i>John Doe</i>		75. SIGNATURE OF WITNESS <i>John Doe</i>		76. SIGNATURE OF PHYSICIAN <i>John Doe</i>		77. SIGNATURE OF CORONER <i>John Doe</i>		78. SIGNATURE OF JUDGE <i>John Doe</i>	
79. SIGNATURE OF DECEASED <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>		81. SIGNATURE OF PHYSICIAN <i>John Doe</i>		82. SIGNATURE OF CORONER <i>John Doe</i>		83. SIGNATURE OF JUDGE <i>John Doe</i>	
84. SIGNATURE OF DECEASED <i>John Doe</i>		85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF PHYSICIAN <i>John Doe</i>		87. SIGNATURE OF CORONER <i>John Doe</i>		88. SIGNATURE OF JUDGE <i>John Doe</i>	
89. SIGNATURE OF DECEASED <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>		91. SIGNATURE OF PHYSICIAN <i>John Doe</i>		92. SIGNATURE OF CORONER <i>John Doe</i>		93. SIGNATURE OF JUDGE <i>John Doe</i>	
94. SIGNATURE OF DECEASED <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF PHYSICIAN <i>John Doe</i>		97. SIGNATURE OF CORONER <i>John Doe</i>		98. SIGNATURE OF JUDGE <i>John Doe</i>	
99. SIGNATURE OF DECEASED <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Doe</i>		101. SIGNATURE OF PHYSICIAN <i>John Doe</i>		102. SIGNATURE OF CORONER <i>John Doe</i>		103. SIGNATURE OF JUDGE <i>John Doe</i>	

9467

CERTIFICATE OF DEATH

Reg. Dist. No.

09475

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights			
c. LENGTH OF STAY IN lb 27 Days				d. STREET ADDRESS 1120 65th Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elizabeth Tyler				4. DATE OF DEATH Aug. 25 1959			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-5-90	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid White House				10b. KIND OF BUSINESS OR INDUSTRY Madison Co., Va.		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thornton Lambert				14. MOTHER'S MAIDEN NAME Lula Jentons			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Mary Lewis 6405 7th St., N.W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X Carcinomatous CA. of Cervix. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7-29 , 19 59 , to 8-24 , 19 59 , that I last saw the deceased alive on 8-24 , 19 59 , and that death occurred at 8:15 A.M. from the causes and on the date stated above.							
22. ADDRESS (Street, city or town, state) 6202 Ager Rd Hyattsville Md							
23. ACTUAL SIGNATURE William R. Greco M.D. Dr. William R. Greco M.D.							
24. PHYSICIAN'S NAME (Type) Dr. William R. Greco M.D.							
25. BURIAL, CREMATION, REMOVAL (Specify) Burial							
26. DATE THEREOF 8-29-59							
27. NAME OF CEMETERY OR CREMATORY Lincoln Memorial							
28. LOCATION (City, town, or county) (State) Suitland, Maryland							
29. FUNERAL DIRECTOR'S SIGNATURE Myrtle B. Hollis ADDRESS 4339 Hunt Pl. S.E.							
30. REC'D BY REGISTRAR AUG 31 '59							
31. REGISTRAR'S SIGNATURE Arthur S. Thomas							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CENTRICITY OF DEATH

1947

ST. JOHN'S HOSPITAL

ST. JOHN'S HOSPITAL

ST. JOHN'S HOSPITAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

9392 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
CERTIFICATE OF DEATH									
Reg. Dist. No. 09476									
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wash. DC.			47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor-4922 Lz Saller Rd					d. STREET ADDRESS 1307-Quincy ST N.E.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HANNAH Middle R. Last WALLACE			4. DATE OF DEATH Month 8- Day 26 Year 1959						
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 3, 1870		9. AGE (In years last birthday) 88 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Somersworth N.H.			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME John Rowan				14. MOTHER'S MAIDEN NAME Mary Frazier					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. No		INFORMANT Sr. Cecilia Regina O. Carm			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO-SCLEROTIC HEART DISEASE (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SEVERE GENERALIZED OSTEOPOROSIS									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/10, 1956, to 8/26, 1959, that I last saw the deceased alive on 8/24, 1959, and that death occurred at 8:30 A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE R.C. Kirchner				ADDRESS (Street, city or town, state) 6480-N.H. Ave				DATE SIGNED 8-26-59	
PHYSICIAN'S NAME (Type) R.C. KIRCHNER				Takoma Park Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-29-59		22c. NAME OF CEMETERY OR CREMATORY NEW ROLLINSFORD SEM.			22d. LOCATION (City, town, or county) (State) ROLLINSFORD, N. H.		
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins				ADDRESS 3821-14th Ave		24a. REC'D BY REGISTRAR DATE AUG 27 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Turner	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City and County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

9468

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09477

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Dead on arrival		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradbury Heights					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 4904 R Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Bryson Eastman Ward				4. DATE OF DEATH Month Day Year August 1, 19 59					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 17, 1911			
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME George E. Ward				14. MOTHER'S MAIDEN NAME Josephine McMurray					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-03-5564		17. INFORMANT Donald Ross Ward, same as # 2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause last. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 8/4/59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln			
22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.									
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Inc.				24a. REC'D BY REGISTRAR DATE AUG 6 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus			

2330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

9511

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09478

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD (DISTRICT OF COLUMBIA) P.G. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS		c. LENGTH OF STAY IN 1b 8 HOURS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS AAFB WASH25 DC		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PAULINE Middle H Last WEAVER		4. DATE OF DEATH Month AUGUST Day 26 Year 19 59	
5. SEX FEMALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 7 1923
9. AGE (In years lost birthday) 36 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GOVERNMENT EMPLOYEE	
11. BIRTHPLACE (State or foreign country) HOBBTOWN, ARKANSAS		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BROSE HOBBS		14. MOTHER'S MAIDEN NAME BUENA MILLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 421-42-3581	
17. INFORMANT ROY E WEAVER (HUSBAND)		Address SEE SECTION 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA (CARCINOMATOSIS) 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA OF BREAST DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 25 AUGUST , 19 59 , to 26 AUGUST , 19 59 , that I last saw the deceased alive on AUGUST 26 , 19 59 , and that death occurred at 4:40A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Paul H Jacobs M.D. USAF HOSP ANDREWS AAFB WASH 25 DC 26 AUG 59 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) PAUL H JACOBS CAPT USAF MC USAF HOSPITAL ANDREWS ANDREWS AFB WASH 25 DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 1, 1959	
22c. NAME OF CEMETERY OR CREMATORY FORT SMITH NAT. CEMETERY		22d. LOCATION (City, town, or county) (State) FORT SMITH ARKANSAS	
23. FUNERAL DIRECTOR'S SIGNATURE RINALDI FUNERAL HOME 816 H ST. N.E.		24a. REC'D BY REGISTRAR DATE AUG 28 59	
ADDRESS WASH, D.C.		24b. REGISTRAR'S SIGNATURE Curtis E. Hume	

10178

CERTIFICATE OF DEATH

0311

STATE OF MISSOURI

DEPARTMENT OF HEALTH

COUNTY OF [illegible]

DATE OF DEATH [illegible]

TIME OF DEATH [illegible]

PLACE OF DEATH [illegible]

CAUSE OF DEATH [illegible]

AGE [illegible]

SEX [illegible]

RACE [illegible]

EDUCATION [illegible]

OCCUPATION [illegible]

RELIGION [illegible]

MARRIAGE [illegible]

PREVIOUS ILLNESS [illegible]

PREVIOUS SURGERY [illegible]

PREVIOUS TRAUMA [illegible]

PREVIOUS DRUGS [illegible]

PREVIOUS ALCOHOL [illegible]

PREVIOUS TOBACCO [illegible]

PREVIOUS OTHER [illegible]

9512

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09479

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellsville Md.				c. LENGTH OF STAY IN 1b 56 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Enterprise Road				d. STREET ADDRESS Enterprise Road			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Pierce Middle Francis Last Weaver				4. DATE OF DEATH Month August Day 29 Year 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 1, 1894	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY self		11. BIRTHPLACE (State or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Harry P Weaver				14. MOTHER'S MAIDEN NAME Augusta Harrison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Annie E Weaver Address Mitchellsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO (c) generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) chronic congestive heart failure with pulmonary edema INTERVAL BETWEEN ONSET AND DEATH 30 min 5 years many years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 1 , 19 59 , to 8/29 , 19 59 , that I last saw the deceased alive on 8/26 , 19 59 , and that death occurred at 4:35 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED H. James Kurta M.D. R F D Bowie Md 8/29/59 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) H. James Kurta R F D Bowie, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF Sept 2, 1959							
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery							
22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.							
24a. REC'D BY REGISTRAR DATE SEP 1 '59							
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9384

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G246 8-12-59 et

CERTIFICATE OF DEATH

09480

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Pr. Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>West Va</i> b. COUNTY <i>Pocahontas</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cass - West Va</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Nigeria still Private Res.</i>		d. STREET ADDRESS <i>85 x -3</i>	
3. NAME OF DECEASED (Type or print) <i>BESSIE</i> First Middle Last		4. DATE OF DEATH <i>Aug 1, 1959</i> Month Day Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 19, 1900</i> yrs. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>West Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Oscar Ketterman</i>		14. MOTHER'S MAIDEN NAME <i>Martha Thompson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>2513</i>	
17. INFORMANT <i>Bea O. White</i> Address <i>West Va</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Carcinomatosis</i> 153.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause last. (b) <i>Carcinoma of Ascending Colon</i> DUE TO (c) <i></i>			INTERVAL BETWEEN ONSET AND DEATH <i>6 mo.</i> <i>2 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May 20, 1959</i> to <i>Aug 1, 1959</i> , that I last saw the deceased alive on <i>July 29, 1959</i> , and that death occurred at <i>5 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R.D. Bauer M.D.</i> M.D.		ADDRESS (Street, city or town, state) <i>2513 Buck Lodge Rd. S. 1/1/59</i> DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>R.D. BAUER, M.D.</i>		<i>Adelphi Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>Aug 1, 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Elkton</i>	22d. LOCATION (City, town, or county) (State) <i>West Virginia</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasche Sons Hyattsville Md</i> ADDRESS		24a. REC'D BY REGISTRAR <i>AUG 3 '59</i> DATE	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

9469

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G247 8-31-59 et

CERTIFICATE OF DEATH

09481

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 1 Day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 34 Brentwood d. STREET ADDRESS 4408 41st St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Agatha Willett				4. DATE OF DEATH Month Aug. Day 22 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-7-85	
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME William T Allison		14. MOTHER'S MAIDEN NAME Katherine E. Mears	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. no none		INFORMANT Julius Willett 4408 41st St Brentwood, Md.			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 60x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arterio-sclerotic Disease DUE TO (c) Diabetes							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10:40 19 52 to Aug. 22 19 59 and that death occurred at 11:40 AM from the causes and on the date stated above. alive on Aug. 22 19 59 , and that death occurred at 11:40 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED C. C. Hageage 3308 Perry St. Mt Rainier, Md. 8/22/59							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) C. C. Hageage 3308 Perry St Mt Rainier Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 25, 1959		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE AUG 26 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Frank			

MEDICAL CERTIFICATION

3220

CERTIFICATE OF DEATH

Blank form with faint horizontal lines and ghosted text from the reverse side.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9470

09482

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 8 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson Heights	
3. NAME OF DECEASED (Type or print) First Middle Last Andrew Lawrence Williams		4. DATE OF DEATH Month Day Year August 9 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 14, 1921
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George E. Williams		14. MOTHER'S MAIDEN NAME Mamie Powell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Cherry Williams; same address as # 2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO 983X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral lacerations DUE TO (c) Multiple fractures of skull			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck on head several time with a ball peen hammer.	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 6:00 p.m. 8-8- 1959		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Jefferson Heights Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED August 9, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8-13-59	22c. NAME OF CEMETERY OR CREMATORY POWELL CEMETERY EMPORIA VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhine Est Co.		24a. REC'D BY REGISTRAR DATE AUG 12 '59	
ADDRESS 3015-14 STREET N.E. WASH.-DC.		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

MAINE AND STATE DEPARTMENT OF HEALTH - BATHING IS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
George E. Williams		August 11, 1931	
RESIDENCE		PLACE OF DEATH	
Maine		Bath, Maine	
AGE		SEX	
60 years		Male	
RACE		OCCUPATION	
Colored		Laborer	
BIRTH DATE		BIRTH PLACE	
Jan. 11, 1871		Virginia	
MARRIAGE		CAUSE OF DEATH	
None		Coronary thrombosis	
PREVIOUS ILLNESS		MANNER OF DEATH	
None		Natural	
SIGNATURE OF EXAMINER		SIGNATURE OF WITNESSES	
George E. Williams		None	
DATE		PLACE	
August 11, 1931		Bath, Maine	

George E. Williams, aged 60 years, male, colored, born Jan. 11, 1871, at Virginia, West Virginia, died at Bath, Maine, on August 11, 1931, of coronary thrombosis, natural causes.

Witnesses: John T. Sawyer, N.Y.

August 11, 1931

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

9471

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09483

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherryland</u> <u>Realmanor</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Reverdale</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>6100 Somerset Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>James C. Boyd</u>		4. DATE OF DEATH <u>Aug 21 1959</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 11, 1891</u>		9. AGE (In years last birthday) <u>68</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>			
13. FATHER'S NAME <u>James C. Williams</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>Yes</u> <u>CWWI</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Marthy Williams, same as *</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Aug 21, 1959</u>				DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 25, 1959</u>		22c. NAME OF CEMETERY OR CREMATOR <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR <u>Aug 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 N

9513

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09484

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Pr. Geo's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 3, Box 209		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Kenneth Middle G. Last Wilson		4. DATE OF DEATH Month August Day 3 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 21, 1905
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Tobacco)		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME J. Burns Wilson		14. MOTHER'S MAIDEN NAME Henrietta Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Edna Connick Wilson-- Address Same as above.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Cardiovascular disease (c) 5-10 minutes		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 46 to July 59 , that I last saw the deceased alive on July 59 , and that death occurred at 10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Clinton Medical Center, Aug. 3, 59 DATE SIGNED ACTUAL SIGNATURE Alfred R. Lapin M.D. Clinton, Maryland PHYSICIAN'S NAME (Type) ALFRED R. LAPIN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/5/59	
22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		22d. LOCATION (City, town, or county) (State) Baden Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.		24a. REC'D BY REGISTRAR AUG 11 '59	
24b. REGISTRAR'S SIGNATURE Charles E. Kline			

10-10-32

CERTIFICATE OF DEATH

0513

(M)

State of New York
County of New York
City of New York
I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the 10th day of October, 1932, at New York City, New York, I attended the deceased, *[Name]*, who died at the age of *[Age]* years, of the following disease or diseases, to-wit: *[Disease]*, and that the death was caused by the above disease or diseases, and that the deceased was not a victim of any contagious or infectious disease, and that the death was not caused by any criminal act or omission, and that the deceased was not a victim of any mental disease, and that the death was not caused by any other cause than the above disease or diseases.

[Signature]
Physician
Witness my hand and seal this 10th day of October, 1932, at New York City, New York.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.)
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

9472

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09486

1. PLACE OF DEATH a. COUNTY <u>Prince Georges County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Geoges General Hospital</u>		d. STREET ADDRESS <u>Box 355</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Morris Maurice Windsor</u>		4. DATE OF DEATH Month Day Year <u>Aug 11 19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/24/00</u>
9. AGE (In years lost birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming (Tobacco)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tenant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Windsor</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT Address <u>Wm. Alvin Windsor- Upper Marlboro, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>terminal</u> 157X DUE TO <u>metastatic carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ca of pancreas</u> (c) <u>ca of pancreas</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/4</u> , 19 <u>59</u> , to <u>8/11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug 11</u> , 19 <u>59</u> , and that death occurred at <u>7:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. DeRubens</u>		ADDRESS (Street, city or town, state) <u>Prince Georges G. Hosp</u> DATE SIGNED <u>8/12/59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. DeRubens</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/14/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Upper Marlboro Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros.</u> ADDRESS <u>Upper Marlboro, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 18 59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	

1
Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9473

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10624

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 Hr 40Min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS Route 2, Box 142		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Boy Wyvill First Middle Last				4. DATE OF DEATH Aug. 20 1959 Month Day Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1959		9. AGE (In years last birthday) yrs. 2	IF UNDER 1 YEAR Months 2 Days 40	IF UNDER 24 HRS. Hours 40
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) U.S.A. - Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Wyvill				14. MOTHER'S MAIDEN NAME Shirley Buck			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Address Mother, Mrs Shirley Wyvill Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Pnevmonia DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 h-10min						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 20 , 19 59 , to Aug. 20 , 19 59 , that I last saw the deceased alive on Aug. 20 , 19 59 , and that death occurred at 6P , M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE John Kehoe M.D.				PHYSICIAN'S NAME (Type) Dr John Kehoe			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Sept 4, 1959		22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital		22d. LOCATION (City, town, or county) (State) Cheverly, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Pennington Jr., Administrator Cheverly, Maryland				24. REC'D BY REGISTRAR DATE SEP 10 59		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

2077288XVI

CERTIFICATE OF DEATH

9473

First Name

Last Name

Sex

Age

Color

Height

Weight

Place of Birth

Date of Birth

Place of Birth

Signature

Signature

Witness

Witness

[Handwritten Signature]

Aug. 10, 1958

Aug. 10, 1958

Aug. 10, 1958

58

58

58

1000

1000

1000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9474

CERTIFICATE OF DEATH

Reg. Dist. No.

10625

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last York		4. DATE OF DEATH Month August Day 23 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/23/59
9. AGE (In years last birthday) 7		10. IF UNDER 1 YEAR Months 7 Days 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME John P		14. MOTHER'S MAIDEN NAME Nancy Jane Stanley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Nancy Mother Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 760.5 Prematurity DUE TO (b) Subarachnoid hemorrhage DUE TO (c) lying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 23, 19 59 , to August 23, 19 59 , that I last saw the deceased alive on August 23, 19 59 , and that death occurred at 3:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6905 Baltimore Ave. College Park, Md. DATE SIGNED			
ACTUAL SIGNATURE Thomas A. Christensen M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) Dr. Thomas A. Christensen M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Sept 4, 1959	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital		22d. LOCATION (City, town, or county) (State) Cheverly, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. ADDRESS Chesley, Maryland		24a. REC'D BY REGISTRAR SEP 10 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Knead			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09487

1. PLACE OF DEATH a. COUNTY Prince George		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley		c. LENGTH OF STAY IN 1b 9 Days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mt. Rainier		d. STREET ADDRESS 3424 Newton St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Elmer Ambrose Ziegler		4. DATE OF DEATH Month Day Year Aug. 22 1959		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 30, 1890		9. AGE (In years lost birthday) 68 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, not retired) Painter Printing Office		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Clay Center, Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME David Paul Ziegler		14. MOTHER'S MAIDEN NAME Ollie F. Morris		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none	
16. SOCIAL SECURITY NO. none		17. INFORMANT L. Bertrude Ziegler		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pulmonary embolism 584X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Chronic cholecystitis & cholelithiasis DUE TO (c) Chronic cholecystitis & cholelithiasis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4 months		INTERVAL BETWEEN ONSET AND DEATH 4 months		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Aug. 13 , 19 59 , to Aug. 22 , 19 59 , that I last saw the deceased alive on Aug. 22 , 19 59 , and that death occurred at 10A. M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 1726 Eye St. N.W. Wash. D.C.		DATE SIGNED 8/23/59	
ACTUAL SIGNATURE Saul Schwartzback		M.D. 1726 Eye St. N.W. Wash. D.C.		PHYSICIAN'S NAME (Type) Dr. Saul Schwartzback		M.D. M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-25-59		22c. NAME OF CEMETERY OR CREMATORY St. Luke's	
22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.		23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home Inc.		ADDRESS 3300 L. St. Mt. Rainier, Md.		24a. REC'D BY REGISTRAR DATE AUG 26 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Evans		25. REGISTRAR'S SIGNATURE Arthur L. Evans		26. REGISTRAR'S SIGNATURE Arthur L. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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